Application for a §1915(c) Home and Community-Based Services Waiver

PURPOSE OF THE HCBS WAIVER PROGRAM

The Medicaid Home and Community-Based Services (HCBS) waiver program is authorized in §1915(c) of the Social Security Act. The program permits a State to furnish an array of home and community-based services that assist Medicaid beneficiaries to live in the community and avoid institutionalization. The State has broad discretion to design its waiver program to address the needs of the waiver's target population. Waiver services complement and/or supplement the services that are available to participants through the Medicaid State plan and other federal, state and local public programs as well as the supports that families and communities provide.

The Centers for Medicare & Medicaid Services (CMS) recognizes that the design and operational features of a waiver program will vary depending on the specific needs of the target population, the resources available to the State, service delivery system structure, State goals and objectives, and other factors. A State has the latitude to design a waiver program that is cost-effective and employs a variety of service delivery approaches, including participant direction of services.

Request for a Renewal to a §1915(c) Home and Community-Based Services Waiver

1. Major Changes

Describe any significant changes to the approved waiver that are being made in this renewal application:
no significant changes

Application for a §1915(c) Home and Community-Based Services Waiver

1. Request Information (1 of 3)

A. The **State** of **Washington** requests approval for a Medicaid home and community-based services (HCBS) waiver under the authority of §1915(c) of the Social Security Act (the Act).

B. **Program Title** (*optional - this title will be used to locate this waiver in the finder*):
Medically Needy In Home Waiver

C. **Type of Request: renewal**

☐ **Migration Waiver**

☑ **Renewal of Waiver:** *(Base Number.Revision Level)*

WA . 0419 **.**

Original Waiver Effective Date: *(mm/dd/yy)*

Waiver Number: WA.02.01.00

D. **Type of Waiver** *(select only one):*
Regular Waiver

E. **Proposed Effective Date:** *(mm/dd/yy)*
05/01/07

Approved Effective Date: 05/01/07

1. Request Information (2 of 3)

F. Level(s) of Care. This waiver is requested in order to provide home and community-based waiver services to individuals who, but for the provision of such services, would require the following level(s) of care, the costs of which would be reimbursed under the approved Medicaid State plan (*check each that applies*):

☐ **Hospital**

Select applicable level of care

○ **Hospital as defined in 42 CFR §440.10**

If applicable, specify whether the State additionally limits the waiver to subcategories of the hospital level of care:

○ **Inpatient psychiatric facility for individuals age 21 and under as provided in42 CFR §440.160**

☑ **Nursing Facility**

Select applicable level of care

◉ **Nursing Facility As defined in 42 CFR §440.40 and 42 CFR §440.155**

If applicable, specify whether the State additionally limits the waiver to subcategories of the nursing facility level of care:

○ **Institution for Mental Disease for persons with mental illnesses aged 65 and older as provided in 42 CFR §440.140**

☐ **Intermediate Care Facility for the Mentally Retarded (ICF/MR) (as defined in 42 CFR §440.150)**

If applicable, specify whether the State additionally limits the waiver to subcategories of the ICF/MR level of care:

1. Request Information (3 of 3)

G. Concurrent Operation with Other Programs. This waiver operates concurrently with another program (or programs) approved under the following authorities

Select one:

◉ **Not applicable**

○ **Applicable**

Check the applicable authority or authorities:

☐ **Services furnished under the provisions of §1915(a) of the Act and described in Appendix I**

☐ **Waiver(s) authorized under §1915(b) of the Act.**

Specify the §1915(b) waiver program and indicate whether a §1915(b) waiver application has been submitted or previously approved:

Specify the §1915(b) authorities under which this program operates *(check each that applies):*

☐ **§1915(b)(1) (mandated enrollment to managed care)**

☐ **§1915(b)(2) (central broker)**

☐ **§1915(b)(3) (employ cost savings to furnish additional services)**

☐ **§1915(b)(4) (selective contracting/limit number of providers)**

☐ **A program authorized under §1115 of the Act.**

Specify the program:

2. Brief Waiver Description

Brief Waiver Description. *In one page or less*, briefly describe the purpose of the waiver, including its goals, objectives, organizational structure (e.g., the roles of state, local and other entities), and service delivery methods.

The Medically Needy In-Home Waiver (MNIW) provides home and community-based services targeted to aged and

disabled individuals who are at nursing facility level of care and classified as medically needy for purposes of eligibility. The waiver is for people who receive waiver services in their homes instead of institutions, group homes, or assisted living facilities.

The waiver is administered by the State Department of Social and Health Services (DSHS) through the Aging and Disabilities Services Administration (ADSA). The state determines initial financial and functional eligibility for services. Ongoing case management is provided by local Area Agencies on Aging (AAA).

The goal of this waiver is to support participants in their own homes rather than in nursing facilities or other more restrictive settings. The objective of the Waiver is to develop and implement supports and services to successfully maintain individuals in their homes and communities. Each participant receives an individual assessment and a written plan tailored to meet their individual needs. The waiver includes the following services:
- Personal Care
- Personal Emergency Response
- Environmental Modifications
- Skilled Nursing
- Transportation
- Home Health Aide Services
- Adult Day Care
- Caregiver/Recipient Training Services
- Home Delivered Meals
- Specialized Medical Equipment and Supplies
- In Home Nurse Delegation
- Community Transition Services

Waiver participants who need personal care can choose their own individual provider or obtain services through a home care agency. Personal care providers are required to pass a background check and go through state provided training.

The waiver can serve up to 200 people (unduplicated yearly count) who meet financial and functional criteria. More information on this waiver and other aging and disability services in Washington State can be found at: http://www.adsa.dshs.wa.gov.

3. Components of the Waiver Request

The waiver application consists of the following components. *Note: Item 3-E must be completed.*

A. Waiver Administration and Operation. Appendix A specifies the administrative and operational structure of this waiver.

B. Participant Access and Eligibility. Appendix B specifies the target group(s) of individuals who are served in this waiver, the number of participants that the State expects to serve during each year that the waiver is in effect, applicable Medicaid eligibility and post-eligibility (if applicable) requirements, and procedures for the evaluation and reevaluation of level of care.

C. Participant Services. Appendix C specifies the home and community-based waiver services that are furnished through the waiver, including applicable limitations on such services.

D. Participant-Centered Service Planning and Delivery. Appendix D specifies the procedures and methods that the State uses to develop, implement and monitor the participant-centered service plan (of care).

E. Participant-Direction of Services. When the State provides for participant direction of services, **Appendix E** specifies the participant direction opportunities that are offered in the waiver and the supports that are available to participants who direct their services. (*Select one*):

- (●) **Yes. This waiver provides participant direction opportunities.** *Appendix E is required.*
- ( ) **No. This waiver does not provide participant direction opportunities.** *Appendix E is not required.*

F. Participant Rights. Appendix F specifies how the State informs participants of their Medicaid Fair Hearing rights and other procedures to address participant grievances and complaints.

G. Participant Safeguards. Appendix G describes the safeguards that the State has established to assure the health and welfare of waiver participants in specified areas.

H. Quality Management Strategy. Appendix H contains the Quality Management Strategy for this waiver.

I. Financial Accountability. Appendix I describes the methods by which the State makes payments for waiver services, ensures the integrity of these payments, and complies with applicable federal requirements concerning payments and federal financial participation.

J. Cost-Neutrality Demonstration. Appendix J contains the State's demonstration that the waiver is cost-neutral.

4. Waiver(s) Requested

A. Comparability. The State requests a waiver of the requirements contained in §1902(a)(10)(B) of the Act in order to provide the services specified in **Appendix C** that are not otherwise available under the approved Medicaid State plan to individuals who: (a) require the level(s) of care specified in Item 1.F and (b) meet the target group criteria specified in **Appendix B**.

B. Income and Resources for the Medically Needy. Indicate whether the State requests a waiver of §1902(a)(10)(C)(i)(III) of the Act in order to use institutional income and resource rules for the medically needy *(select one)*:

- ○ **Not Applicable**
- ○ **No**
- ◉ **Yes**

C. Statewideness. Indicate whether the State requests a waiver of the statewideness requirements in §1902(a)(1) of the Act *(select one)*:

- ◉ **No**
- ○ **Yes**

If yes, specify the waiver of statewideness that is requested *(check each that applies)*:

☐ **Geographic Limitation.** A waiver of statewideness is requested in order to furnish services under this waiver only to individuals who reside in the following geographic areas or political subdivisions of the State.
Specify the areas to which this waiver applies and, as applicable, the phase-in schedule of the waiver by geographic area:

☐ **Limited Implementation of Participant-Direction.** A waiver of statewideness is requested in order to make *participant-direction of services* as specified in **Appendix E** available only to individuals who reside in the following geographic areas or political subdivisions of the State. Participants who reside in these areas may elect to direct their services as provided by the State or receive comparable services through the service delivery methods that are in effect elsewhere in the State.
Specify the areas of the State affected by this waiver and, as applicable, the phase-in schedule of the waiver by geographic area:

5. Assurances

In accordance with 42 CFR §441.302, the State provides the following assurances to CMS:

A. Health & Welfare: The State assures that necessary safeguards have been taken to protect the health and welfare of persons receiving services under this waiver. These safeguards include:

1. As specified in **Appendix C**, adequate standards for all types of providers that provide services under this waiver;

2. Assurance that the standards of any State licensure or certification requirements specified in **Appendix C** are

met for services or for individuals furnishing services that are provided under the waiver. The State assures that these requirements are met on the date that the services are furnished; and,

3. Assurance that all facilities subject to §1616(e) of the Act where home and community-based waiver services are provided comply with the applicable State standards for board and care facilities as specified in **Appendix C**.

B. Financial Accountability. The State assures financial accountability for funds expended for home and community-based services and maintains and makes available to the Department of Health and Human Services (including the Office of the Inspector General), the Comptroller General, or other designees, appropriate financial records documenting the cost of services provided under the waiver. Methods of financial accountability are specified in **Appendix I**.

C. Evaluation of Need: The State assures that it provides for an initial evaluation (and periodic reevaluations, at least annually) of the need for a level of care specified for this waiver, when there is a reasonable indication that an individual might need such services in the near future (one month or less) but for the receipt of home and community based services under this waiver. The procedures for evaluation and reevaluation of level of care are specified in **Appendix B**.

D. Choice of Alternatives: The State assures that when an individual is determined to be likely to require the level of care specified for this waiver and is in a target group specified in **Appendix B**, the individual (or, legal representative, if applicable) is:

1. Informed of any feasible alternatives under the waiver; and,

2. Given the choice of either institutional or home and community based waiver services. **Appendix B** specifies the procedures that the State employs to ensure that individuals are informed of feasible alternatives under the waiver and given the choice of institutional or home and community-based waiver services.

E. Average Per Capita Expenditures: The State assures that, for any year that the waiver is in effect, the average per capita expenditures under the waiver will not exceed 100 percent of the average per capita expenditures that would have been made under the Medicaid State plan for the level(s) of care specified for this waiver had the waiver not been granted. Cost-neutrality is demonstrated in **Appendix J**.

F. Actual Total Expenditures: The State assures that the actual total expenditures for home and community-based waiver and other Medicaid services and its claim for FFP in expenditures for the services provided to individuals under the waiver will not, in any year of the waiver period, exceed 100 percent of the amount that would be incurred in the absence of the waiver by the State's Medicaid program for these individuals in the institutional setting(s) specified for this waiver.

G. Institutionalization Absent Waiver: The State assures that, absent the waiver, individuals served in the waiver would receive the appropriate type of Medicaid-funded institutional care for the level of care specified for this waiver.

H. Reporting: The State assures that annually it will provide CMS with information concerning the impact of the waiver on the type, amount and cost of services provided under the Medicaid State plan and on the health and welfare of waiver participants. This information will be consistent with a data collection plan designed by CMS.

I. Habilitation Services. The State assures that prevocational, educational, or supported employment services, or a combination of these services, if provided as habilitation services under the waiver are: (1) not otherwise available to the individual through a local educational agency under the Individuals with Disabilities Education Act (IDEA) or the Rehabilitation Act of 1973; and, (2) furnished as part of expanded habilitation services.

J. Services for Individuals with Chronic Mental Illness. The State assures that federal financial participation (FFP) will not be claimed in expenditures for waiver services including, but not limited to, day treatment or partial hospitalization, psychosocial rehabilitation services, and clinic services provided as home and community-based services to individuals with chronic mental illnesses if these individuals, in the absence of a waiver, would be placed in an IMD and are: (1) age 22 to 64; (2) age 65 and older and the State has not included the optional Medicaid benefit cited in 42 CFR §440.140; or (3) age 21 and under and the State has not included the optional Medicaid benefit cited

in 42 CFR § 440.160.

6. Additional Requirements

Note: Item 6-I must be completed.

A. Service Plan. In accordance with 42 CFR §441.301(b)(1)(i), a participant-centered service plan (of care) is developed for each participant employing the procedures specified in **Appendix D**. All waiver services are furnished pursuant to the service plan. The service plan describes: (a) the waiver services that are furnished to the participant, their projected frequency and the type of provider that furnishes each service and (b) the other services (regardless of funding source, including State plan services) and informal supports that complement waiver services in meeting the needs of the participant. The service plan is subject to the approval of the Medicaid agency. Federal financial participation (FFP) is not claimed for waiver services furnished prior to the development of the service plan or for services that are not included in the service plan.

B. Inpatients. In accordance with 42 CFR §441.301(b)(1) (ii), waiver services are not furnished to individuals who are in-patients of a hospital, nursing facility or ICF/MR.

C. Room and Board. In accordance with 42 CFR §441.310(a)(2), FFP is not claimed for the cost of room and board except when: (a) provided as part of respite services in a facility approved by the State that is not a private residence or (b) claimed as a portion of the rent and food that may be reasonably attributed to an unrelated caregiver who resides in the same household as the participant, as provided in **Appendix I**.

D. Access to Services. The State does not limit or restrict participant access to waiver services except as provided in **Appendix C**.

E. Free Choice of Provider. In accordance with 42 CFR §431.151, a participant may select any willing and qualified provider to furnish waiver services included in the service plan unless the State has received approval to limit the number of providers under the provisions of §1915(b) or another provision of the Act.

F. FFP Limitation. In accordance with 42 CFR §433 Subpart D, FFP is not claimed for services when another third-party (e.g., another third party health insurer or other federal or state program) is legally liable and responsible for the provision and payment of the service. FFP also may not be claimed for services that are available without charge, or as free care to the community. Services will not be considered to be without charge, or free care, when (1) the provider establishes a fee schedule for each service available and (2) collects insurance information from all those served (Medicaid, and non-Medicaid), and bills other legally liable third party insurers. Alternatively, if a provider certifies that a particular legally liable third party insurer does not pay for the service(s), the provider may not generate further bills for that insurer for that annual period.

G. Fair Hearing: The State provides the opportunity to request a Fair Hearing under 42 CFR §431 Subpart E, to individuals: (a) who are not given the choice of home and community- based waiver services as an alternative to institutional level of care specified for this waiver; (b) who are denied the service(s) of their choice or the provider(s) of their choice; or (c) whose services are denied, suspended, reduced or terminated. **Appendix F** specifies the State's procedures to provide individuals the opportunity to request a Fair Hearing, including providing notice of action as required in 42 CFR §431.210.

H. Quality Management. The State operates a formal, comprehensive system to ensure that the waiver meets the assurances and other requirements contained in this application. Through an ongoing process of discovery, remediation and improvement, the State assures the health and welfare of participants by monitoring: (a) level of care determinations; (b) individual plans and services delivery; (c) provider qualifications; (d) participant health and welfare; (e) financial oversight and (f) administrative oversight of the waiver. The State further assures that all problems identified through its discovery processes are addressed in an appropriate and timely manner, consistent with the severity and nature of the problem. During the period that the waiver is in effect, the State will implement the Quality Management Strategy specified in **Appendix H**.

I. Public Input. Describe how the State secures public input into the development of the waiver:
The State secures public input by working closely with the following:
-The Legislature

-Other divisions and state agencies,(mental health, Alcohol and Substance Abuse, Vocational Rehabilitation, Health, Medical)

The Medicaid Agency meets regularly with the following to share information and obtain input on program design and quality of care.
-State Quality Assurance Advisory Committee which includes family members, clients, providers and other stakeholders
-County Coordinators for Human Services,
-The Washington Association of Area Agencies on Aging
-Provider associations: Home Care, Home health, Nursing Facility
-Boarding Home and Adult Family Home Advisory Boards
-Governor's Disability Council
-Senior Lobby
-Senior Council on Aging (Governor's committee)
-Older Adults Advisory Committee (mental health)
-North West Justice Project
-Quarterly Case Management meetings

Input on waiver development is obtained from participant satisfaction surveys.

The State maintains a government to government relationship with the federally recognized Tribes in the state. This includes written accords, a formal process for consultation and a process for informal input.

J. Notice to Tribal Governments. The State assures that it has notified in writing all federally-recognized Tribal Governments that maintain a primary office and/or majority population within the State of the State's intent to submit a Medicaid waiver request or renewal request to CMS at least 60 days before the anticipated submission date is provided by Presidential Executive Order 13175 of November 6, 2000. Evidence of the applicable notice is available through the Medicaid Agency.

K. Limited English Proficient Persons. The State assures that it provides meaningful access to waiver services by Limited English Proficient persons in accordance with: (a) Presidential Executive Order 13166 of August 11, 2000 (65 FR 50121) and (b) Department of Health and Human Services "Guidance to Federal Financial Assistance Recipients Regarding Title VI Prohibition Against National Origin Discrimination Affecting Limited English Proficient Persons" (68 FR 47311 - August 8, 2003). **Appendix B** describes how the State assures meaningful access to waiver services by Limited English Proficient persons.

7. Contact Person(s)

A. The Medicaid agency representative with whom CMS should communicate regarding the waiver is:

Last Name:	Imhoff
First Name:	Chris
Title:	HCBS Waiver Manager
Agency:	Aging and Disability Services Administration
Address:	P.O. Box 45600
Address 2:	
City	Olympia
State:	**Washington**
Zip:	98504
Phone:	(360) 725-2272 **ext.**
Fax:	(360) 438-8633
E-mail:	

imhofc@dshs.wa.gov

B. If applicable, the State operating agency representative with whom CMS should communicate regarding the waiver is:

Last Name:
First Name:
Title:
Agency:
Address:
Address 2:
City
State: **Washington**
Zip:
Phone: **ext.**
Fax:
E-mail:

8. Authorizing Signature

This document, together with Appendices A through J, constitutes the State's request for a waiver under §1915(c) of the Social Security Act. The State assures that all materials referenced in this waiver application (including standards, licensure and certification requirements) are ***readily*** available in print or electronic form upon request to CMS through the Medicaid agency or, if applicable, from the operating agency specified in Appendix A. Any proposed changes to the waiver will be submitted by the Medicaid agency to CMS in the form of waiver amendments.
Upon approval by CMS, the waiver application serves as the State's authority to provide home and community-based waiver services to the specified target groups. The State attests that it will abide by all provisions of the approved waiver and will continuously operate the waiver in accordance with the assurances specified in Section 5 and the additional requirements specified in Section 6 of the request.

Signature: Kathy Leitch

State Medicaid Director or Designee

Submission Date: Feb 28, 2007

Last Name: Arnold-Williams
First Name: Robin
Title: Secretary
Agency: Department of Social and Health Services
Address: P.O. Box 45010
Address 2:
City: Olympia
State: **Washington**
Zip: 98504-5010

Phone: (360) 902-7800

Fax: (360) 902-7848

E-mail: ArnolR@dshs.wa.gov

Attachment #1: Transition Plan

Specify the transition plan for the waiver:

N/A

Appendix A: Waiver Administration and Operation

1. **State Line of Authority for Waiver Operation.** Specify the state line of authority for the operation of the waiver (*select one*):

   - (selected) **The waiver is operated by the State Medicaid agency.**

     Specify the Medicaid agency division/unit that has line authority for the operation of the waiver program *(select one: do not complete Item A-2)*:

     - ( ) **The Medical Assistance Unit.**

       Specify the unit name:

     - (selected) **Another division/unit within the State Medicaid agency that is separate from the Medical Assistance Unit.**

       Specify the unit name:
       Aging and Disabilities Services Administration
       Do not complete item A-2.

   - ( ) **The waiver is operated by a separate agency of the State that is not a division/unit of the Medicaid agency.**

     Specify the unit name:

     In accordance with 42 CFR §431.10, the Medicaid agency exercises administrative discretion in the administration and supervision of the waiver and issues policies, rules and regulations related to the waiver. The interagency agreement or memorandum of understanding that sets forth the authority and arrangements for this policy is available through the Medicaid agency to CMS upon request. *Complete item A-2.*

Appendix A: Waiver Administration and Operation

2. **Medicaid Agency Oversight of Operating Agency Performance.** When the waiver is not operated by the Medicaid agency, specify the methods that the Medicaid agency uses to ensure that the operating agency performs its assigned waiver operational and administrative functions in accordance with waiver requirements. Also specify the frequency of Medicaid agency assessment of operating agency performance:
   As indicated in section 1 of this appendix, the waiver is not operated by a separate agency of the State. Thus this section does not need to be completed.

Appendix A: Waiver Administration and Operation

3. **Use of Contracted Entities.** Specify whether contracted entities perform waiver operational and administrative functions on behalf of the Medicaid agency and/or the operating agency (if applicable) (*select one*):

   ○ **Yes. Contracted entities perform waiver operational and administrative functions on behalf of the Medicaid agency and/or operating agency (if applicable).**
   Specify the types of contracted entities and briefly describe the functions that they perform. *Complete Items A-5 and A-6.:*

   ◉ **No. Contracted entities do not perform waiver operational and administrative functions on behalf of the Medicaid agency and/or the operating agency (if applicable).**

Appendix A: Waiver Administration and Operation

4. **Role of Local/Regional Non-State Entities.** Indicate whether local or regional non-state entities perform waiver operational and administrative functions and, if so, specify the type of entity (*Select One*):

   ○ **Not applicable**

   ◉ **Applicable** - Local/regional non-state agencies perform waiver operational and administrative functions. Check each that applies:

   ☑ **Local/Regional non-state public agencies** perform waiver operational and administrative functions at the local or regional level. There is an **interagency agreement or memorandum of understanding** between the State and these agencies that sets forth responsibilities and performance requirements for these agencies that is available through the Medicaid agency.

   Specify the nature of these agencies and complete items A-5 and A-6:

   The Medicaid agency contracts with AAAs to perform certain operational and administrative functions at the local level. Some AAAs are single or multi-county entities. One AAA is a non-profit organization (Southwest Washington AAA) and two AAAs are operated by tribes (Colville Indian AAA and Yakama Nation AAA). In all cases, the Medicaid agency has a contract that sets forth the responsibilities and performance requirements of the AAA. The contract is available through the Medicaid agency.

   ☑ **Local/Regional non-governmental non-state entities** conduct waiver operational and administrative functions at the local or regional level. There is a contract between the Medicaid agency and/or the operating agency (when authorized by the Medicaid agency) and each local/regional non-state entity that sets forth the responsibilities and performance requirements of the local/regional entity. The **contract(s)** under which private entities conduct waiver operational functions are available to CMS upon request through the Medicaid agency or the operating agency (if applicable).

   Specify the nature of these entities and complete items A-5 and A-6:

   The Medicaid agency contracts with AAAs to perform certain operational and administrative functions at the local level. Some AAAs are single or multi-county entities. One AAA is a non-profit organization (Southwest Washington AAA) and two AAAs are operated by tribes (Colville Indian AAA and Yakama Nation AAA). In all cases, the Medicaid agency has a contract that sets forth the responsibilities and performance requirements of the AAA. The contract is available through the Medicaid agency.

Appendix A: Waiver Administration and Operation

5. **Responsibility for Assessment of Performance of Contracted and/or Local/Regional Non-State Entities.** Specify the state agency or agencies responsible for assessing the performance of contracted and/or local/regional non-state

entities in conducting waiver operational and administrative functions:
Department of Social and Health Services
Aging and Disability Services Administration

Appendix A: Waiver Administration and Operation

6. **Assessment Methods and Frequency.** Describe the methods that are used to assess the performance of contracted and/or local/regional non-state entities to ensure that they perform assigned waiver operational and administrative functions in accordance with waiver requirements. Also specify how frequently the performance of contracted and/or local/regional non-state entities is assessed:
Performance assessment of non-state entities is performed by the Medicaid agency with methods and frequency as follows:

AAA billings are reviewed on a monthly basis by ADSA fiscal staff and the assigned AAA Specialist. This includes monitoring expenditures against contract balances, ensuring that billed services are in accordance with the AAA's approved Area Plan, etc. ADSA also monitors to ensure that certain required staffing ratios are maintained for case management, nursing, and supervisory positions.

Quality Assurance Specialists (QAS) perform a variety of monitoring activities each review cycle. A review cycle is 18 months. The focus of each review cycle is determined by an analysis of the previous years monitoring results to ensure remediation and improvement. Reviews also focus on ensuring that the CMS protocols are addressed and Washington is in compliance with state and federal regulations. During the 2006-2007 review cycles, QAS staff performed desk compliance audits of 6% of the active regional/AAA clients. The sample size is determined based on accepted statistical sampling methods.

Each QA monitoring cycle includes a review of the information that is disseminated to potential waiver enrollees as well as training materials for staff. Level of care evaluations are reviewed for accuracy and eligibility. Subcontracts are reviewed to ensure that services outlined in the contract are delivered by qualified providers to recipients as outlined in their plan of care. The State Unit on Aging (SUA) which is responsible for AAA contract management participates in each QAS monitoring cycle including being on site for the QAS entrance/exit conferences and approval of Corrective Actions Plans.

In addition to QA monitoring, ADSA completes on site contract and fiscal monitoring every two years. In years when there is not a full review, desk reviews and follow-up on corrective actions are completed on a defined schedule. Monitoring includes whether providers are qualified, that payments are accurate, that authorized services address current needs and that informal supports are reflected. ADSA also monitors the remaining AAA programs based on a risk assessment tool. For example, in 2005 ADSA monitored Fiscal Operations, Senior I&A, Respite, Family Caregiver Support Program, Fiscal Elements of AAA Home Care Agency Monitoring, and Title 5-senior employment.

ADSA follows the requirements of the Single Audit Act and OMB CIRCULAR A-133 in determining audit requirement for AAAs and sub-contractors.

References: AAA Policy Manual Ch. 6

The State Auditor's Office a performs yearly audits of County-based AAAs.AAAs that are not a division of county government are audited annually by a certified public accounting firm.

Appendix A: Waiver Administration and Operation

7. **Distribution of Waiver Operational and Administrative Functions.** In the following table, specify the entity or entities that have responsibility for conducting each of the waiver operational and administrative functions listed (*check each that applies*):
In accordance with 42 CFR §431.10, when the Medicaid agency does not directly conduct a function, it supervises the performance of the function and establishes and/or approves policies that affect the function.

Function	Medicaid Agency	Local Non-State Entity

Disseminate information concerning the waiver to potential enrollees	☑	☑
Assist individuals in waiver enrollment	☑	☐
Manage waiver enrollment against approved limits	☑	☐
Monitor waiver expenditures against approved levels	☑	☐
Conduct level of care evaluation activities	☑	☑
Review participant service plans to ensure that waiver requirements are met	☑	☑
Perform prior authorization of waiver services	☑	☐
Conduct utilization management functions	☑	☐
Recruit providers	☑	☑
Execute the Medicaid provider agreement	☑	☑
Determine waiver payment amounts or rates	☑	☑
Conduct training and technical assistance concerning waiver requirements	☑	☑

Appendix B: Participant Access and Eligibility

B-1: Specification of the Waiver Target Group(s)

a. Target Group(s). Under the waiver of Section 1902(a)(10)(B) of the Act, the State limits waiver services to a group or subgroups of individuals. Please see the instruction manual for specifics regarding age limits. *In accordance with 42 CFR §441.301(b)(6), select one waiver target group, check each of the subgroups in the selected target group that may receive services under the waiver, and specify the minimum and maximum (if any) age of individuals served in each subgroup:*

Target Group	Included	Target SubGroup	Minimum Age	Maximum Age	
				Maximum Age Limit	No Maximum Age Limit
◉ **Aged or Disabled, or Both - General**					
	☑	Aged	65		☑
	☑	Disabled (Physical)	18	64	
	☑	Disabled (Other)	18	64	
○ **Aged or Disabled, or Both - Specific Recognized Subgroups**					
	☐	Brain Injury			☐
	☐	HIV/AIDS			☐
	☐	Medically Fragile			☐
	☐	Technology Dependent			☐
○ **Mental Retardation or Developmental Disability, or Both**					
	☐	Autism			☐
	☐	Developmental Disability			☐
	☐	Mental Retardation			☐
○ **Mental Illness**					
	☐	Mental Illness			
		Serious Emotional Disturbance			

b. Additional Criteria. The State further specifies its target group(s) as follows:

a. Individuals living in their own homes
b. Persons with disabilities may continue to participate in the waiver beyond age 64 specified in the chart.

c. Transition of Individuals Affected by Maximum Age Limitation. When there is a maximum age limit that applies to individuals who may be served in the waiver, describe the transition planning procedures that are undertaken on behalf of participants affected by the age limit *(select one):*

- **Not applicable. There is no maximum age limit**
- **The following transition planning procedures are employed for participants who will reach the waiver's maximum age limit.**

Specify:

The waiver does not have maximum age limits. Persons with disabilities may continue to participate in the waiver beyond age 64 specified in the chart.

Appendix B: Participant Access and Eligibility

B-2: Individual Cost Limit (1 of 2)

a. Individual Cost Limit. The following individual cost limit applies when determining whether to deny home and community-based services or entrance to the waiver to an otherwise eligible individual *(select one)*:

- **No Cost Limit.** The State does not apply an individual cost limit. *Do not complete Item B-2-b or item B-2-c.*
- **Cost Limit in Excess of Institutional Costs.** The State refuses entrance to the waiver to any otherwise eligible individual when the State reasonably expects that the cost of the home and community-based services furnished to that individual would exceed the cost of a level of care specified for the waiver up to an amount specified by the State. *Complete Items B-2-b and B-2-c.*

  The limit specified by the State is *(select one)*

  - **A level higher than 100% of the institutional average.**

    Specify the percentage:

  - **Other**

    Specify:

- **Institutional Cost Limit.** Pursuant to 42 CFR 441.301(a)(3), the State refuses entrance to the waiver to any otherwise eligible individual when the State reasonably expects that the cost of the home and community-based services furnished to that individual would exceed 100% of the cost of the level of care specified for the waiver. *Complete Items B-2-b and B-2-c.*
- **Cost Limit Lower Than Institutional Costs.** The State refuses entrance to the waiver to any otherwise qualified individual when the State reasonably expects that the cost of home and community-based services furnished to that individual would exceed the following amount specified by the State that is less than the cost of a level of care specified for the waiver.

Specify the basis of the limit, including evidence that the limit is sufficient to assure the health and welfare of waiver participants. Complete Items B-2-b and B-2-c.

The cost limit specified by the State is *(select one)*:

- **The following dollar amount:**

  Specify dollar amount:

  The dollar amount *(select one)*

  - **Is adjusted each year that the waiver is in effect by applying the following formula:**

    Specify the formula:

  - **May be adjusted during the period the waiver is in effect. The State will submit a waiver amendment to CMS to adjust the dollar amount.**
- **The following percentage that is less than 100% of the institutional average:**

  Specify percent:

- **Other:**

  Specify:

Appendix B: Participant Access and Eligibility

B-2: Individual Cost Limit (2 of 2)

Answers provided in Appendix B-2-a indicate that you do not need to complete this section.

b. Method of Implementation of the Individual Cost Limit. When an individual cost limit is specified in Item B-2-a, specify the procedures that are followed to determine in advance of waiver entrance that the individual's health and welfare can be assured within the cost limit:

c. Participant Safeguards. When the State specifies an individual cost limit in Item B-2-a and there is a change in the participant's condition or circumstances post-entrance to the waiver that requires the provision of services in an amount that exceeds the cost limit in order to assure the participant's health and welfare, the State has established the following safeguards to avoid an adverse impact on the participant *(check each that applies)*:

- **The participant is referred to another waiver that can accommodate the individual's needs.**
- **Additional services in excess of the individual cost limit may be authorized.**

Specify the procedures for authorizing additional services, including the amount that may be authorized:

Other safeguard(s)

Specify:

Appendix B: Participant Access and Eligibility

B-3: Number of Individuals Served (1 of 4)

a. Unduplicated Number of Participants. The following table specifies the maximum number of unduplicated participants who are served in each year that the waiver is in effect. The State will submit a waiver amendment to CMS to modify the number of participants specified for any year(s), including when a modification is necessary due to legislative appropriation or another reason. The number of unduplicated participants specified in this table is basis for the cost-neutrality calculations in Appendix J:

Table: B-3-a

Waiver Year	Unduplicated Number of Participants
Year 1	200
Year 2	200
Year 3	200
Year 4 (renewal only)	200
Year 5 (renewal only)	200

b. Limitation on the Number of Participants Served at Any Point in Time. Consistent with the unduplicated number of participants specified in Item B-3-a, the State may limit to a lesser number the number of participants who will be served at any point in time during a waiver year. Indicate whether the State limits the number of participants in this way: *(select one)*:

- **The State does not limit the number of participants that it serves at any point in time during a waiver year.**
- **The State limits the number of participants that it serves at any point in time during a waiver year.**

The limit that applies to each year of the waiver period is specified in the following table:

Table: B-3-b

Waiver Year	Maximum Number of Participants Served At Any Point During the Year
Year 1	
Year 2	
Year 3	
Year 4 (renewal only)	
Year 5 (renewal only)	

Appendix B: Participant Access and Eligibility

B-3: Number of Individuals Served (2 of 4)

c. Reserved Waiver Capacity. The State may reserve a portion of the participant capacity of the waiver for specified purposes (e.g., provide for the community transition of institutionalized persons or furnish waiver services to individuals experiencing a crisis) subject to CMS review and approval. The State *(select one)*:

- (●) **Not applicable. The state does not reserve capacity.**
- ( ) **The State reserves capacity for the following purpose(s).**

Appendix B: Participant Access and Eligibility

B-3: Number of Individuals Served (3 of 4)

d. Scheduled Phase-In or Phase-Out. Within a waiver year, the State may make the number of participants who are served subject to a phase-in or phase-out schedule *(select one)*:

- (●) **The waiver is not subject to a phase-in or a phase-out schedule.**
- ( ) **The waiver is subject to a phase-in or phase-out schedule that is included in Attachment #1 to Appendix B-3. This schedule constitutes an intra-year limitation on the number of participants who are served in the waiver.**

e. Allocation of Waiver Capacity.

Select one:

- (●) **Waiver capacity is allocated/managed on a statewide basis.**
- ( ) **Waiver capacity is allocated to local/regional non-state entities.**

Specify: (a) the entities to which waiver capacity is allocated; (b) the methodology that is used to allocate capacity and how often the methodology is reevaluated; and, (c) policies for the reallocation of unused capacity among local/regional non-state entities:

f. Selection of Entrants to the Waiver. Specify the policies that apply to the selection of individuals for entrance to the waiver:

The state does not anticipate deferring the entrance of otherwise eligible persons.

Appendix B: Participant Access and Eligibility

B-3: Number of Individuals Served - Attachment #1 (4 of 4)

Answers provided in Appendix B-3-d indicate that you do not need to complete this section.

Appendix B: Participant Access and Eligibility

B-4: Eligibility Groups Served in the Waiver

a. State Classification. The State is a *(select one)*:

- (●) **§1634 State**
- ( ) **SSI Criteria State**
- ( ) **209(b) State**

b. Medicaid Eligibility Groups Served in the Waiver. Individuals who receive services under this waiver are eligible under the following eligibility groups contained in the State plan. The State applies all applicable federal financial

participation limits under the plan. *Check all that apply*:

Eligibility Groups Served in the Waiver (excluding the special home and community-based waiver group under 42 CFR §435.217)

- ☐ **Low income families with children as provided in §1931 of the Act**
- ☐ **SSI recipients**
- ☐ **Aged, blind or disabled in 209(b) states who are eligible under 42 CFR §435.121**
- ☐ **Optional State supplement recipients**
- ☐ **Optional categorically needy aged and/or disabled individuals who have income at:**

Select one:

- ○ **100% of the Federal poverty level (FPL)**
- ○ **% of FPL, which is lower than 100% of FPL.**

Specify percentage:

- ☐ **Working individuals with disabilities who buy into Medicaid (BBA working disabled group as provided in §1902(a)(10)(A)(ii)(XIII)) of the Act)**
- ☐ **Working individuals with disabilities who buy into Medicaid (TWWIIA Basic Coverage Group as provided in §1902(a)(10)(A)(ii)(XV) of the Act)**
- ☐ **Working individuals with disabilities who buy into Medicaid (TWWIIA Medical Improvement Coverage Group as provided in §1902(a)(10)(A)(ii)(XVI) of the Act)**
- ☐ **Disabled individuals age 18 or younger who would require an institutional level of care (TEFRA 134 eligibility group as provided in §1902(e)(3) of the Act)**
- ☑ **Medically needy**
- ☐ **Other specified groups (include only statutory/regulatory reference to reflect the additional groups in the State plan that may receive services under this waiver)**

Specify:

Special home and community-based waiver group under 42 CFR §435.217) *Note: When the special home and community-based waiver group under 42 CFR §435.217 is included, Appendix B-5 must be completed*

- ○ **No. The State does not furnish waiver services to individuals in the special home and community-based waiver group under 42 CFR §435.217.** *Appendix B-5 is not submitted.*
- ◉ **Yes. The State furnishes waiver services to individuals in the special home and community-based waiver group under 42 CFR §435.217.**

Select one and complete Appendix B-5.

- ○ **All individuals in the special home and community-based waiver group under 42 CFR §435.217**
- ◉ **Only the following groups of individuals in the special home and community-based waiver group under 42 CFR §435.217**

Check each that applies:

- ☐ **A special income level equal to:**

Select one:

- **300% of the SSI Federal Benefit Rate (FBR)**
- **A percentage of FBR, which is lower than 300% (42 CFR §435.236)**

  Specify percentage:
- **A dollar amount which is lower than 300%.**

  Specify dollar amount:

- **Aged, blind and disabled individuals who meet requirements that are more restrictive than the SSI program (42 CFR §435.121)**
- **Medically needy without spenddown in States which also provide Medicaid to recipients of SSI (42 CFR §435.320, §435.322 and §435.324)**
- **Medically needy without spend down in 209(b) States (42 CFR §435.330)**
- **Aged and disabled individuals who have income at:**

  Select one:

  - **100% of FPL**
  - **% of FPL, which is lower than 100%.**

    Specify percentage amount:
- **Other specified groups (include only statutory/regulatory reference to reflect the additional groups in the State plan that may receive services under this waiver)**

  Specify:

Appendix B: Participant Access and Eligibility

B-5: Post-Eligibility Treatment of Income (1 of 4)

In accordance with 42 CFR §441.303(e), Appendix B-5 must be completed when the State furnishes waiver services to individuals in the special home and community-based waiver group under 42 CFR §435.217, as indicated in Appendix B-4. Post-eligibility applies only to the 42 CFR §435.217 group. A State that uses spousal impoverishment rules under §1924 of the Act to determine the eligibility of individuals with a community spouse may elect to use spousal post-eligibility rules under §1924 of the Act to protect a personal needs allowance for a participant with a community spouse.

a. Use of Spousal Impoverishment Rules. Indicate whether spousal impoverishment rules are used to determine eligibility for the special home and community-based waiver group under 42 CFR §435.217 *(select one):*

- **Spousal impoverishment rules under §1924 of the Act are used to determine the eligibility of individuals with a community spouse for the special home and community-based waiver group.**

  In the case of a participant with a community spouse, the State elects to (*select one*):

  - **Use spousal post-eligibility rules under §1924 of the Act.**
    (Complete Item B-5-b (SSI State) and Item B-5-d)
  - **Use regular post-eligibility rules under 42 CFR §435.726 (SSI State) or under §435.735 (209b State)**
    (Complete Item B-5-b (SSI State) . Do not complete Item B-5-d)

○ **Spousal impoverishment rules under §1924 of the Act are not used to determine eligibility of individuals with a community spouse for the special home and community-based waiver group. The State uses regular post-eligibility rules for individuals with a community spouse.**
(Complete Item B-5-b (SSI State) . Do not complete Item B-5-d)

Appendix B: Participant Access and Eligibility

B-5: Post-Eligibility Treatment of Income (2 of 4)

b. Regular Post-Eligibility Treatment of Income: SSI State.

The State uses the post-eligibility rules at 42 CFR 435.726 for individuals who do not have a spouse or have a spouse who is not a community spouse as specified in §1924 of the Act. Payment for home and community-based waiver services is reduced by the amount remaining after deducting the following allowances and expenses from the waiver participant's income:

i. Allowance for the needs of the waiver participant (*select one*):

◉ **The following standard included under the State plan**

Select one:

○ **SSI standard**
○ **Optional State supplement standard**
◉ **Medically needy income standard**
○ **The special income level for institutionalized persons**

(*select one*):

○ **300% of the SSI Federal Benefit Rate (FBR)**
○ **A percentage of the FBR, which is less than 300%**

Specify the percentage: [ ]

○ **A dollar amount which is less than 300%.**

Specify dollar amount: [ ]

○ **A percentage of the Federal poverty level**

Specify percentage: [ ]

○ **Other**

Specify:

[ ]

○ **The following dollar amount**

Specify dollar amount: [ ] If this amount changes, this item will be revised.

○ **The following formula is used to determine the needs allowance:**

Specify:

ii. Allowance for the spouse only (*select one*):

- (●) **Not Applicable**
- ( ) **The state provides an allowance for a spouse who does not meet the definition of a community spouse in §1924 of the Act. Describe the circumstances under which this allowance is provided:**

Specify:

Specify the amount of the allowance (*select one*):

- ( ) **SSI standard**
- ( ) **Optional State supplement standard**
- ( ) **Medically needy income standard**
- ( ) **The following dollar amount:**

Specify dollar amount: If this amount changes, this item will be revised.

- ( ) **The amount is determined using the following formula:**

Specify:

iii. Allowance for the family (*select one*):

- ( ) **Not Applicable (see instructions)**
- ( ) **AFDC need standard**
- (●) **Medically needy income standard**
- ( ) **The following dollar amount:**

Specify dollar amount: The amount specified cannot exceed the higher of the need standard for a family of the same size used to determine eligibility under the State's approved AFDC plan or the medically needy income standard established under 42 CFR §435.811 for a family of the same size. If this amount changes, this item will be revised.

- ( ) **The amount is determined using the following formula:**

Specify:

- ( ) **Other**

Specify:

iv. Amounts for incurred medical or remedial care expenses not subject to payment by a third party,

specified in 42 §CFR 435.726:

a. Health insurance premiums, deductibles and co-insurance charges
b. Necessary medical or remedial care expenses recognized under State law but not covered under the State's Medicaid plan, subject to reasonable limits that the State may establish on the amounts of these expenses.

Select one:

- **Not Applicable (see instructions)**
- **The State does not establish reasonable limits.**
- **The State establishes the following reasonable limits**

Specify:

The deduction for medical and remedial care expenses that were incurred as the result of imposition of a transfer of assets penalty is limited to zero.

Appendix B: Participant Access and Eligibility

B-5: Post-Eligibility Treatment of Income (3 of 4)

c. Regular Post-Eligibility Treatment of Income: 209(B) State.

Answers provided in Appendix B-4 indicate that you do not need to complete this section and therefore this section is not visible.

Appendix B: Participant Access and Eligibility

B-5: Post-Eligibility Treatment of Income (4 of 4)

d. Post-Eligibility Treatment of Income Using Spousal Impoverishment Rules

The State uses the post-eligibility rules of §1924(d) of the Act (spousal impoverishment protection) to determine the contribution of a participant with a community spouse toward the cost of home and community-based care if it determines the individual's eligibility under §1924 of the Act. There is deducted from the participant's monthly income a personal needs allowance (as specified below), a community spouse's allowance, a family allowance, and an amount for incurred expenses for medical or remedial care.

i. Allowance for the personal needs of the waiver participant

(*select one*):

- **SSI standard**
- **Optional State supplement standard**
- **Medically needy income standard**
- **The special income level for institutionalized persons**
- **A percentage of the Federal poverty level**

Specify percentage:

- **The following dollar amount:**

Specify dollar amount: If this amount changes, this item will be revised

- **The following formula is used to determine the needs allowance:**

  Specify formula:

- **Other**

  Specify:

ii. If the allowance for the personal needs of a waiver participant with a community spouse is different from the amount used for the individual's maintenance allowance under 42 CFR §435.726 or 42 CFR §435.735, explain why this amount is reasonable to meet the individual's maintenance needs in the community.

Select one:

- **Allowance is the same**
- **Allowance is different.**

Explanation of difference:

iii. Amounts for incurred medical or remedial care expenses not subject to payment by a third party, specified in 42 §CFR 435.726:

a. Health insurance premiums, deductibles and co-insurance charges
b. Necessary medical or remedial care expenses recognized under State law but not covered under the State's Medicaid plan, subject to reasonable limits that the State may establish on the amounts of these expenses.

Select one:

- **Not Applicable (see instructions)**
- **The State does not establish reasonable limits.**
- **The State uses the same reasonable limits as are used for regular (non-spousal) post-eligibility.**

Appendix B: Participant Access and Eligibility

B-6: Evaluation/Reevaluation of Level of Care

As specified in 42 CFR §441.302(c), the State provides for an evaluation (and periodic reevaluations) of the need for the level(s) of care specified for this waiver, when there is a reasonable indication that an individual may need such services in the near future (one month or less), but for the availability of home and community-based waiver services.

a. Reasonable Indication of Need for Services. In order for an individual to be determined to need waiver services, an individual must require: (a) the provision of at least one waiver service, as documented in the service plan, and (b) the provision of waiver services at least monthly or, if the need for services is less than monthly, the participant requires regular monthly monitoring which must be documented in the service plan. Specify the State's policies concerning the reasonable indication of the need for services:

i. **Minimum number of services.**

The minimum number of waiver services (one or more) that an individual must require in order to be determined to need waiver services is: 1

ii. **Frequency of services.** The State requires (select one):

- (•) **The provision of waiver services at least monthly**
- ( ) **Monthly monitoring of the individual when services are furnished on a less than monthly basis**

If the State also requires a minimum frequency for the provision of waiver services other than monthly (e.g., quarterly), specify the frequency:

b. **Responsibility for Performing Evaluations and Reevaluations.** Level of care evaluations and reevaluations are performed (*select one*):

- ( ) **Directly by the Medicaid agency**
- ( ) **By the operating agency specified in Appendix A**
- ( ) **By an entity under contract with the Medicaid agency.**

Specify the entity:

- (•) **Other**

Specify:

The Medicaid agency performs the initial evaluation for level of care. Re-evaluations are performed by Area Agencies on Aging who are under contract with the Medicaid agency.

c. **Qualifications of Individuals Performing Initial Evaluation:** Per 42 CFR §441.303(c)(1), specify the educational/professional qualifications of individuals who perform the initial evaluation of level of care for waiver applicants:

In addition to meeting the following minimum qualifications, staff must pass a background check prior to being hired and receive mandatory training prior to completing any evaluations.

Initial evaluations are performed by case managers who can be a Registered Nurse (licensed in the State)or a Social Worker. For Social Workers, minimum qualifications are as follows:

A Master's degree in social services, human services, behavioral sciences, or an allied field and two years of paid social service experience equivalent to a Social Worker 2.

OR

A Bachelor's degree in social services, human services, behavioral sciences, or an allied field, and three years of paid social service experience performing functions equivalent to a Social Worker 2.

NOTE: A two year Master's degree in one of the above fields that included a practicum will be substituted for one year of paid social service experience.

NOTE: Employees must successfully complete the formal training course sponsored by their division within one year of their appointment.

NOTE: Equivalent social service experience would include the previous classes of Caseworker 3 or higher.

OR

For Promotion Only: A Bachelor's degree and three years of experience as a Caseworker 3, Social Worker 1A or B, Social Worker 2, Casework Supervisor Trainee, Casework Supervisor, Juvenile Rehabilitation Supervisor 1 or 2, or

Juvenile Rehabilitation Counselor 2 in State service.

Job classification discriptions are available from the Medicaid agency.

d. Level of Care Criteria. Fully specify the level of care criteria that are used to evaluate and reevaluate whether an individual needs services through the waiver and that serve as the basis of the State's level of care instrument/tool. Specify the level of care instrument/tool that is employed. State laws, regulations, and policies concerning level of care criteria and the level of care instrument/tool are available to CMS upon request through the Medicaid agency or the operating agency (if applicable), including the instrument/tool utilized.

The level of care criteria that are used to evaluate and reevaluate whether an individual needs services through the waiver and that serve as the basis of the State's level of care instrument/tool is fully specified in WAC 388-106-0355.

NFLOC is based on the following factors:
1. The Comprehensive Assessment Reporting Eavaluation (CARE)tool is the assessment tool used to determine NFLOC. Functional criteria for NFLOC means one of the following applies:

a. Care is required to be provided by or under the supervision of a registered nurse or a licensed practical nurse on a daily basis;

b. The individual has an unmet or partially met need with at least three of the following activities of daily living. For each ADL a minimum level of assistance is required in self performance and/or support provided (self performance and support provided is defined below).

The minimum level of assistance required for each ADL is:
-Eating - Support provided is setup; or
-Toileting and bathing - Self performance is supervision; or
-Transfer, bed mobility, and ambulation - Self performance is supervision and support provided is setup; or
-Medication management - Self performance is assistance required; or
-If the need for assistance in any activities listed in this section did not occur because the individual was unable or no provider was available to assist, that need is counted for the purpose in determining functional eligibility; or

c. The individual has an unmet or partially met need with at least two of the following activities of daily living:
The minimum level of assistance required for each ADL is:
-Eating - Self performance is supervision and support provided one person physical assist; or
-Toileting - Self performance is extensive assistance and support provided is one person physical assist; or
-Bathing - Self performance is limited assistance and support provided is one person physical assist; or
-Transfer and Mobility - Self performance is extensive assistance and support provided is one person physical assist; or
-Bed Mobility – includes limited assistance in self performance and the need for turning and repositioning; and support provided is one person physical assist;
-Medication Management – Assistance required daily in self performance; or
-If the need for assistance in any activities listed in this section did not occur because the individual was unable or no provider was available to assist, that need is counted for the purpose in determining functional eligibility; or

(d) The individual has a cognitive impairment and requires supervision due to one or more of the following: Disorientation, memory impairment, impaired decision making, or wandering and have an unmet or partially met need with at least one or more of the following:
The minimum level of assistance required for each ADL is:
-Eating - Self performance is supervision and support provided one person physical assist; or
-Toileting - Self performance is extensive assistance and support provided is one person physical assist; or
-Bathing - Self performance is limited assistance and support provided is one person physical assist; or
-Transfer and Mobility - Self performance is extensive assistance and support provided is one person physical assist; or
-Bed Mobility – includes limited assistance in self performance and the need for turning and repositioning; and support provided is one person physical assist;
-Medication Management – Assistance required daily in self performance; or
-If the need for assistance in any activities listed in this section did not occur because the individual was unable or no provider was available to assist, that need is counted for the purpose in determining functional eligibility.

"Self performance for ADLs" means what the individual actually did in the last seven days before the assessment,

not what he/she might be capable of doing. Coding is based on the level of performance that occurred three or more times in the seven-day period. Self-performance definitions and assessments are consistant with that used under the Minimum Data Set (MDS). This provides a common set of clinical data across all long term care settings.Self performance level is scored as:

(a) Independent if the individual received no help or oversight, or if the individual needed help or oversight only once or twice;

(b) Supervision if the individual received oversight (monitoring or standby), encouragement, or cueing three or more times;

(c) Limited assistance if the individual was highly involved in the activity and given physical help in guided maneuvering of limbs or other nonweight bearing assistance on three or more occasions. For bathing, limited assistance means physical help is limited to transfer only;

(d) Extensive assistance if the individual performed part of the activity, but on three or more occasions, the individual needed weight bearing support or the individual received full performance of the activity during part, but not all, of the activity. For bathing, extensive assistance means the individual needed physical help with part of the activity (other than transfer);

(e) Total dependence if the individual received full caregiver performance of the activity and all subtasks during the entire seven-day period from others. Total dependence means complete nonparticipation by the individual in all aspects of the ADL; or

(f) Activity did not occur if the individual or others did not perform an ADL over the last seven days before the individual's assessment. The activity may not have occurred because:

(i) The individual was not able (e.g., walking, if paralyzed);

(ii) No provider was available to assist; or

(iii) The individual declined assistance with the task.

"Support provided" means the highest level of support provided to the individual by others in the last seven days before the assessment, even if that level of support occurred only once.

(a) No set-up or physical help provided by others;

(b) Set-up help only provided, which is the type of help characterized by providing the individual with articles, devices, or preparation necessary for greater self performance of the activity. (For example, set-up help includes but is not limited to giving or holding out an item or cutting food);

(c) One-person physical assist provided;

(d) Two- or more person physical assist provided; or

(e) Activity did not occur during entire seven-day period.

Washington uses an automated assessment system called the Comprehensive Assessment Reporting Evaluation (CARE) tool to evaluate and reevaluate level of care criteria required by the waiver. The CARE tool is available to CMS upon request through the Medicaid agency.
The functions, elements and scoring mechanisms of CARE are spelled out in the Washington State Administrative Code (WAC). The following WACs govern CARE and CARE classifications;

388-106-0050 What is an assessment?
388-106-0055 What is the purpose of an assessment?
388-106-0060 Who must perform the assessment?
388-106-0065 What is the process for conducting an assessment?
388-106-0070 Will I be assessed in CARE?
388-106-0075 How is my need for personal care services assessed in CARE?
388-106-0080 How is the amount of long-term care services I can receive in my own home or in a residential facility

determined?
388-106-0085 What criteria does the CARE tool use to place me in one of the classification groups?
388-106-0090 How does the CARE tool measure cognitive performance?
388-106-0095 How does the CARE tool measure clinical complexity?
388-106-0100 How does the CARE tool measure mood and behaviors?
388-106-0105 How does the CARE tool measure activities of daily living (ADLs)?
388-106-0110 How does the CARE tool evaluate me for the exceptional care classification of in-home care?
388-106-0115 How does CARE use the criteria of cognitive performance as determined under WAC 388-106-0090, clinical complexity as determined under WAC 388-106-0095, mood/behaviors as determined under WAC 388-106-0100, and ADLs as determined under WAC 388-106-0105 to place me in a classification group for residential facilities?
388-106-0120 What is the payment rate that the department will pay the provider if I receive personal care services in a residential facility?
388-106-0125 How does CARE use the criteria of cognitive performance as determined under WAC 388-106-0090, clinical complexity as determined under WAC 388-106-0095, mood/behaviors as determined under WAC 388-106-0100, ADLs as determined under WAC 388-106-0105, and exceptional care as determined under WAC 388-106-0110, to place me in a classification group for in-home care?
388-106-0130 How does the department determine the number of hours I may receive for in-home care?
388-106-0135 What are the maximum hours that I can receive for in-home services?
388-106-0140 What will change the maximum hours I can receive?

e. Level of Care Instrument(s). Per 42 CFR §441.303(c)(2), indicate whether the instrument/tool used to evaluate level of care for the waiver differs from the instrument/tool used to evaluate institutional level of care *(select one)*:

- (●) **The same instrument is used in determining the level of care for the waiver and for institutional care under the State Plan.**
- ( ) **A different instrument is used to determine the level of care for the waiver than for institutional care under the State plan.**

Describe how and why this instrument differs from the form used to evaluate institutional level of care and explain how the outcome of the determination is reliable, valid, and fully comparable.

f. Process for Level of Care Evaluation/Reevaluation: Per 42 CFR §441.303(c)(1), describe the process for evaluating waiver applicants for their need for the level of care under the waiver. If the reevaluation process differs from the evaluation process, describe the differences:

Case managers complete Level of Care evaluations using the automated assessment tool (CARE). CARE is used for both initial evaluations and re-evaluations. The re-evaluation process does not differ from the initial evaluation process. Evaluations are completed initially, at annual review, and when a significant change occurs. State case managers' complete initial evaluations and AAA case managers complete annual and significant change reviews. The recipient's assigned case manager is responsible for completing re-evaluations.

Information about the person's support needs is obtained via a face to face interview. Evaluators also obtain and verify information by collateral contacts with formal and informal supports including physicians, home health agencies, caregivers and family.

g. Reevaluation Schedule. Per 42 CFR §441.303(c)(4), reevaluations of the level of care required by a participant are conducted no less frequently than annually according to the following schedule *(select one)*:

- ( ) **Every three months**
- ( ) **Every six months**
- ( ) **Every twelve months**
- (●) **Other schedule**
  Specify the other schedule:

Re-evaluations must be comleted every twelve months and whenever there is a significant change.

h. Qualifications of Individuals Who Perform Reevaluations. Specify the qualifications of individuals who perform reevaluations *(select one)*:

- (●) **The qualifications of individuals who perform reevaluations are the same as individuals who perform initial evaluations.**

The qualifications are different.
Specify the qualifications:

i. **Procedures to Ensure Timely Reevaluations.** Per 42 CFR §441.303(c)(4), specify the procedures that the State employs to ensure timely reevaluations of level of care *(specify):*

The Social Services Payment System (SSPS) produces a report for each case manger that lists each authorization that is expiring or about to expire. Case managers use this information to assure the timeliness of annual reviews in addition to tickler reports produced by CARE.

HCS and AAA supervisors have a required schedule of record reviews for individual case managers and are responsible for evaluating staff on assessment timeliness. In addition, supervisors use reports produced by CARE to track timeliness of assessments.

Quality assurance staff monitoring of records includes monitoring for timeliness.

j. **Maintenance of Evaluation/Reevaluation Records.** Per 42 CFR §441.303(c)(3), the State assures that written and/or electronically retrievable documentation of all evaluations and reevaluations are maintained for a minimum period of 3 years as required in 45 CFR §74.53. Specify the location(s) where records of evaluations and reevaluations of level of care are maintained:

Electronically retrievable documentation of all evaluations and reevaluations is maintained for a minimum of three years at the state level. Written documentation of all evaluation and reevaluations are maintained for a minimum of three years at the local office.

Appendix B: Participant Access and Eligibility

B-7: Freedom of Choice

Freedom of Choice. *As provided in 42 CFR §441.302(d), when an individual is determined to be likely to require a level of care for this waiver, the individual or his or her legal representative is:*

i. *informed of any feasible alternatives under the waiver; and*
ii. *given the choice of either institutional or home and community-based services.*

a. **Procedures.** Specify the State's procedures for informing eligible individuals (or their legal representatives) of the feasible alternatives available under the waiver and allowing these individuals to choose either institutional or waiver services. Identify the form(s) that are employed to document freedom of choice. The form or forms are available to CMS upon request through the Medicaid agency or the operating agency (if applicable).

The Department uses, a form called “Acknowledgement of Services”, (DSHS 14-22) to document the applicant/recipient’s freedom to choose between institutional and home and community-based services. The DSHS 14-225 is explained to the individual and a signature is obtained stating that the individual understands they have a choice in the type of services received, where the service is provided as well as the right to a fair hearing. The individual signs this form to designate the service choice.

Fair Hearing information is contained on the DSHS document 14-225, “Acknowledgement of Services” form. Rights to a fair hearing are explained to all clients during the Medicaid application process and again during the assessment process.

The client receives a signed copy of the DSHS 14-225 and a copy of the form is maintained in the applicant/recipients’ case records.

b. **Maintenance of Forms.** Per 45 CFR §74.53, written copies or electronically retrievable facsimiles of Freedom of Choice forms are maintained for a minimum of three years. Specify the locations where copies of these forms are maintained.

Copies of forms are maintained for a minimum of 3 years in the client record at the local office where case management for the client occurs.

Appendix B: Participant Access and Eligibility

B-8: Access to Services by Limited English Proficiency Persons

Access to Services by Limited English Proficient Persons. Specify the methods that the State uses to provide meaningful access to the waiver by Limited English Proficient persons in accordance with the Department of Health and Human Services "Guidance to Federal Financial Assistance Recipients Regarding Title VI Prohibition Against National Origin Discrimination Affecting Limited English Proficient Persons" (68 FR 47311 - August 8, 2003):
The following references govern access to services for Limited English proficient Persons:

RCW 74.04.025 Bilingual services for non-English speaking applicants and recipients -- Bilingual personnel, when -- Primary language pamphlets and written materials.

WAC 388-03 Rules and regulations for the certification of DSHS spoken language interpreters and translators.

WAC 388-271 Limited English proficient services.

DSHS Administrative Policies
6.12 Adjustment of Workload for Staff who Provide Translation and Interpretation Services Outside of their Workload

7.20 Communication Access for Persons Who are Deaf, Deaf/Blind and Hard of Hearing

7.21 Access to Services for Clients who are Limited English Proficient (LEP)

The Department of Social and Health Services and its contractors are required by statute, administrative code and department policy to deliver services that recognize individual and cultural differences. All clients must be given equal access to services, information, and programs whether the department or contracted vendors deliver services. The following are summaries of requirements:
1.Interpreters are used when interpreter services are requested by the client; necessary for a client's eligibility for services; necessary for the client to access services.
2.LEP and Sensory Impaired (SI) clients are informed of their right to request an interpreter or auxiliary aide and are offered interpreter services or auxiliary aids at no cost to them and without significant delay. Children under age 18 are not allowed to serve as interpreters. LEP Interpreters and Translators for spoken language must be certified and/or qualified by DSHS and comply with the DSHS code of professional conduct.
3.To assure access and quality, DSHS maintains a statewide translation contract, American Sign Language contract and Interpreter Brokerage contract for Spoken Languages.
4. If the listed contractors cannot meet the need, or there is an emergency, which requires the immediate attention, staff can access the Language Line.
5. Procedures are in place to obtain translation of official publications, forms and records as well as client specific requests for translations.

Appendix C: Participant Services

C-1: Summary of Services Covered (1 of 2)

a. Waiver Services Summary. *List the services that are furnished under the waiver in the following table. If case management is not a service under the waiver, complete items C-1-b and C-1-c:*

Service Type	Service
Statutory Service	**Home Health Aide**
Statutory Service	**Personal Care**
Other Service	**Adult Day Care**
Other Service	**Caregiver/Recipient Training Services**
Other Service	**Community Transition Services**
Other Service	**Environmental Accessibility Adaptations**
Other Service	**Home Delivered Meals**

Other Service	**In Home Nurse Delegation**
Other Service	**Personal Emergency Response**
Other Service	**Skilled Nursing**
Other Service	**Specialized Medical Equipment and Supplies**
Other Service	**Transportation**

Appendix C: Participant Services

C-1/C-3: Service Specification

State laws, regulations and policies referenced in the specification are readily available to CMS upon request through the Medicaid agency or the operating agency (if applicable).

Service Type:

Statutory Service

Service:

Home Health Aide

Alternate Service Title (if any):

Complete this part for a renewal application or a new waiver that replaces an existing waiver. Select one **:**

- (●) **Service is included in approved waiver. There is no change in service specifications.**
- ( ) **Service is included in approved waiver. The service specifications have been modified.**
- ( ) **Service is not included in the approved waiver.**

Service Definition *(Scope):*
Services defined in 42 CFR §440.70 that are provided in addition to home health aide services furnished under the approved State plan. Home health aide services under the waiver differ in nature, scope, supervision arrangements, or provider type (including provider training and qualifications) from home health aide services in the State plan. The differences from the State plan are as follows: Under the state plan, home health aid services require a physician order and must be provided under the supervision of an RN, occupational therapist, speech therapist or physical therapist. Under the waiver, home health aid services may be provided without a physician order and the tasks in the care plan performed by the aide are supervised by an RN as needed and in coordination with the client's case manager. Home health aid services are not required to meet the requirements for participation in Medicare as provided in 42 CFR 489.28.

Specify applicable (if any) limits on the amount, frequency, or duration of this service:
Service provided only as identified in the participant's CARE assessment and plan.

Service Delivery Method *(check each that applies)*:

- [ ] **Participant-directed as specified in Appendix E**
- [x] **Provider managed**

Specify whether the service may be provided by *(check each that applies)***:**

- [ ] **Legally Responsible Person**
- [ ] **Relative**
- [ ] **Legal Guardian**

Provider Specifications:

Provider Category	Provider Type Title
Individual	**Certified Nursing Assistant**

Agency	Home Health Agency

Appendix C: Participant Services

C-1/C-3: Provider Specifications for Service

Service Type: Statutory Service
Service Name: Home Health Aide

Provider Category:
Individual
Provider Type:
Certified Nursing Assistant
Provider Qualifications
License *(specify):*
Certificate *(specify):*
Certified and registered under Chapter 18.88A RCW and Chapter 246-841 WAC
Other Standard *(specify):*
pass background check
Provider Qualifications
Entity Responsible for Verification:
State or AAA
Frequency of Verification:
Upon contracting and per individual certification schedule

Appendix C: Participant Services

C-1/C-3: Provider Specifications for Service

Service Type: Statutory Service
Service Name: Home Health Aide

Provider Category:
Agency
Provider Type:
Home Health Agency
Provider Qualifications
License *(specify):*
licensed under Chapter 70.127 RCW
Certificate *(specify):*
Other Standard *(specify):*
individual nursing assistants employed by an agency must be certified under Chapter 18.88A RCW and Chapter 246-841 WAC
Provider Qualifications
Entity Responsible for Verification:
State or AAA
Frequency of Verification:
Upon contracting and per license renewal schedule

Appendix C: Participant Services

C-1/C-3: Service Specification

State laws, regulations and policies referenced in the specification are readily available to CMS upon request through the Medicaid agency or the operating agency (if applicable).

Service Type:

Statutory Service

Service:

Personal Care

Alternate Service Title (if any):

Complete this part for a renewal application or a new waiver that replaces an existing waiver. Select one **:**

- (●) **Service is included in approved waiver. There is no change in service specifications.**
- ( ) **Service is included in approved waiver. The service specifications have been modified.**
- ( ) **Service is not included in the approved waiver.**

Service Definition *(Scope):*

Personal care under the waiver differs in scope from personal care services in the State plan in that it may only be provided to waiver participants who are not eligible for State plan personal care or whose needs exceed what can be provided solely under State plan personal care. Assistance is provided to enable waiver participants to accomplish tasks that they would normally do for themselves if they did not have a disability. This assistance may take the form of hands-on assistance (actually performing a task for the person) or cuing to prompt the participant to perform a task. Personal care services may be provided on an episodic or on a continuing basis. Health-related services that are provided may include skilled or nursing care and medication administration to the extent permitted by State law.

Nursing tasks, such as administration of medication, blood, glucose monitoring, ostomy care, simple wound care or straight catheterization, may be delegated under the direction of a licensed, registered nurse if the provider meets the requirements of a nursing assistant certified and/or registered in the State of Washington. The following tasks CANNOT be delegated: Injections, central lines, sterile procedures, and tasks that require nursing judgments.

Personal care includes assistance with bathing, bed mobility, body care, dressing, eating, locomotion in room and immediate living environment, locomotion outside of room and immediate living environment including outdoors, walking, medication management, toileting, transfer and personal hygiene.

Personal care includes assistance the following incidental activities of daily living: meal preparation, ordinary housework, essential shopping, wood supply (when wood is the sole source of heat), travel to medical services, assessment of the need for financial management and telephone use. These incidental activities may not comprise the entirety of the service for an individual.

Personal care may be provided outside of the participant's home as specified in the service plan.

Participants may elect to have employer authority including hiring, firing, scheduling and supervision. If a participant is unable to provide supervision, an alternate supervisor must be identified. Participants may elect to obtain personal care services through a home care agency.

Personal care may be furnished to escort participants to participate in community activities or access other services in the community.

Personal care may be furnished in order to assist a person to function in the work place or as an adjunct to the provision of employment services.

Specify applicable (if any) limits on the amount, frequency, or duration of this service:

•The maximum hours of personal care received are determined by the Medicaid Agency through the approved department assessment for Medicaid Personal Care services.
•Provider rates are determined by the Legislature based on negotiations between the union representing individual providers and the Governor's office, and state statute for home care agencies.
•Payments flow directly from the Single State Agency to the agency provider or individual provider of services.

•Body care excludes:

(i) Foot care if you are diabetic or have poor circulation; or

(ii) Changing bandages or dressings when sterile procedures are required.

Service Delivery Method *(check each that applies)*:

- ☑ **Participant-directed as specified in Appendix E**
- ☑ **Provider managed**

Specify whether the service may be provided by *(check each that applies)***:**

- ☐ **Legally Responsible Person**
- ☑ **Relative**
- ☑ **Legal Guardian**

Provider Specifications:

Provider Category	Provider Type Title
Individual	personal assistant
Agency	home care agency/home health agency

Appendix C: Participant Services

C-1/C-3: Provider Specifications for Service

Service Type: Statutory Service
Service Name: Personal Care

Provider Category:
Individual

Provider Type:
personal assistant

Provider Qualifications

License *(specify):*

Certificate *(specify):*

Other Standard *(specify):*
Individual providers must contract with the Department before providing MNIW personal care services. The case manager is responsible for completing all contracting steps. Prior to contracting the case manager must verify that the individual provider:
a. Is authorized to work in the United States
b. Passes a three part background check (see general specifications)

Individual providers must complete that following training requiremens:
1. Caregiver orientation within 14 days
2. Revised Fundamentals of Caregiving must be completed within 120 days of employment. Note: An IP may take the Modified Fundamentals of Caregiving Self-Study course in lieu of the full Fundamentals course, if the IP documents successful completion of training as an RN, LPN, nursing assistant certified, PT, OT, or a Medicare certified home care aide.
3. Continuing education of 10 hours each calendar year
4. Required training as outlined in WAC 388-71-05805 through WAC 388-71-05830, for an IP who will be performing a nurse delegated task.

Individual providers of personal care are regulated under the following sections of Washington Administrative Code:

INDIVIDUAL PROVIDER AND HOME CARE AGENCY PROVIDER QUALIFICATIONS
388-71-0500 What is the purpose of WAC 388-71-0500 through 388-71-05909?
388-71-0505 How does a client hire an individual provider?
388-71-0510 How does a person become an individual provider?
388-71-0513 Is a background check required of a home care agency provider?
388-71-0515 What are the responsibilities of an individual provider or home care agency provider when employed to provide care to a client?
388-71-0520 Are there training requirements for an individual provider or a home care agency provider of an adult client?
388-71-0540 When will the department, AAA, or managed care entity deny payment for services of an individual provider or home care agency provider?
388-71-0546 When can the department, AAA, or managed care entity reject the client's choice of an individual provider?
388-71-0551 When can the department, AAA, or managed care entity terminate or summarily suspend an individual provider's contract?
388-71-0556 When can the department, AAA, or managed care entity otherwise terminate an individual provider's contract?
388-71-0560 What are the client's rights if the department denies, terminates, or summarily suspends an individual provider's contract?
388-71-05640 Self-directed care -- Who must direct self-directed care?
388-71-05665 What definitions apply to WAC 388-71-05670 through 388-71-05909?
ORIENTATION
388-71-05670 What is orientation?
388-71-05675 What content must be included in an orientation?
388-71-05680 Is competency testing required for orientation?
388-71-05685 Is there a challenge test for orientation?
388-71-05690 What documentation is required for orientation?
388-71-05695 Who is required to complete orientation, and when must it be completed?
BASIC TRAINING
388-71-05700 What is basic training?
388-71-05705 Is there an alternative to the basic training for some health care workers?
388-71-05710 What core knowledge and skills must be taught in basic training?
388-71-05715 Is competency testing required for basic training?
388-71-05720 Is there a challenge test for basic training?
388-71-05725 What documentation is required for successful completion of basic training?
388-71-05730 Who is required to complete basic training, and when?
MODIFIED BASIC TRAINING
388-71-05735 What is modified basic training?
388-71-05740 What knowledge and skills must be included in modified basic training?
388-71-05745 Is competency testing required for modified basic training?
388-71-05750 Is there a challenge test for modified basic training?
388-71-05755 What documentation is required for successful completion of modified basic training?
388-71-05760 Who may take modified basic training instead of the full basic training?
EXEMPTION FOR IP PARENTS FOR ADULT CHILDREN
388-71-05765 What are the training requirements and exemptions for parents who are individual providers for their adult children receiving services through DDD?
388-71-05770 What are the training requirements and exemptions for parents who are individual providers for their adult children who do not receive services through DDD?
CONTINUING EDUCATION
388-71-05775 What is continuing education?
388-71-05780 How many hours of continuing education are required each year?
388-71-05785 What kinds of training topics are required for continuing education?
388-71-05790 Is competency testing required for continuing education?
388-71-05795 May basic or modified basic training be completed a second time and used to meet the continuing education requirement?
388-71-05799 What are the documentation requirements for continuing education?
NURSE DELEGATION CORE TRAINING
388-71-05805 What is nurse delegation core training?
388-71-05810 What knowledge and skills must nurse delegation core training include?
388-71-05815 Is competency testing required for nurse delegation core training?

388-71-05820 Is there a challenge test for nurse delegation core training?
388-71-05825 What documentation is required for successful completion of nurse delegation core training?
388-71-05830 Who is required to complete nurse delegation core training, and when?
SAFETY TRAINING
388-71-05832 What is safety training?
COMPETENCY TESTING
388-71-05835 What is competency testing?
388-71-05840 What components must competency testing include?
388-71-05845 What experience or training must individuals have to be able to perform competency testing?
388-71-05850 What training must include the DSHS-developed competency test?
388-71-05855 How must competency test administration be standardized?
388-71-05860 What form of identification must providers show a tester before taking a competency or challenge test?
388-71-05865 How many times may a competency test be taken?
INSTRUCTOR QUALIFICATIONS
388-71-05870 What are an instructor's or training entity's responsibilities?
388-71-05875 Must instructors be approved by DSHS or an AAA?
388-71-05880 Can DSHS or the AAA deny or terminate a contract with an instructor or training entity?
388-71-05885 What is a guest speaker, and what are the minimum qualifications to be a guest speaker for basic training?
388-71-05890 What are the minimum qualifications for an instructor for basic, modified basic or nurse delegation core training?
388-71-05895 What additional qualifications are required for instructors of nurse delegation core training?
PHYSICAL RESOURCES AND STANDARD PRACTICES FOR TRAINING
388-71-05899 What must be included in a class on adult education?
388-71-05905 What physical resources are required for basic, modified basic, or nurse delegation core classroom training and testing?
388-71-05909 What standard training practices must be maintained for basic, modified basic, or nurse delegation core classroom training and testing?

Provider Qualifications

Entity Responsible for Verification:

Case manager

Frequency of Verification:

Initially and every two years for background checks. If there is reasonable cause to believe that the provider has been arrested or convicted of a disqualifying crime within the two year cycle, the case manager must complete a new background check.

Annually for required training

New contract required every four years

Appendix C: Participant Services

C-1/C-3: Provider Specifications for Service

Service Type: Statutory Service
Service Name: Personal Care

Provider Category:

Agency

Provider Type:

home care agency/home health agency

Provider Qualifications

License *(specify):*

licensed under chapter 70.127 RCW and chapter 246-336 WAC

Certificate *(specify):*

Other Standard *(specify):*

Provider Qualifications

Entity Responsible for Verification:
State and Area Agency on Aging
Frequency of Verification:
Upon executing/renewing contract
License renewal every two years
Contract compliance monitoring every two years

Appendix C: Participant Services

C-1/C-3: Service Specification

State laws, regulations and policies referenced in the specification are readily available to CMS upon request through the Medicaid agency or the operating agency (if applicable).
Service Type:
Other Service
As provided in 42 CFR §440.180(b)(9), the State requests the authority to provide the following additional service not specified in statute.
Service Title:
Adult Day Care

Complete this part for a renewal application or a new waiver that replaces an existing waiver. Select one **:**

- (•) **Service is included in approved waiver. There is no change in service specifications.**
- ( ) **Service is included in approved waiver. The service specifications have been modified.**
- ( ) **Service is not included in the approved waiver.**

Service Definition *(Scope):*
Adult Day Care: Adult Day Care Services provided in an adult day care center include provision of personal care; routine health monitoring with consultation from a registered nurse; general therapeutic activities; general health education; and supervision and/or protection for at least four hours a day but less than twenty-four hours a day in a group setting on a continuing, regularly scheduled basis.

Services also include: provision of recipient meals as long as meals do not replace nor be a substitute for a full day's nutritional regimen; and, programming and activities designed to meet clients' physical, social and emotional needs. Transportation to and from the program will be obtained through the Title XIX transportation brokers in the areas served by the adult day care.

Adult day care shall be included in a recipient's approved plan of care only when the recipient is; ineligible for adult day health services (Medicaid State Plan covered services): has mild to moderate dementia and/or is chronically ill or disabled; is socially isolated and/or confused; is unable/unsafe to be left alone during the day; needs assistance with personal care; and will benefit from an enriched socially supportive experience.
Specify applicable (if any) limits on the amount, frequency, or duration of this service:
Service provided only as identified in the participant's CARE assessment and plan.

Service Delivery Method *(check each that applies)*:

- [ ] **Participant-directed as specified in Appendix E**
- [x] **Provider managed**

Specify whether the service may be provided by *(check each that applies)*:

- ☐ **Legally Responsible Person**
- ☐ **Relative**
- ☐ **Legal Guardian**

Provider Specifications:

Provider Category	Provider Type Title
Agency	Adult Day Care Center

Appendix C: Participant Services

C-1/C-3: Provider Specifications for Service

Service Type: Other Service
Service Name: Adult Day Care

Provider Category:
Agency
Provider Type:
Adult Day Care Center
Provider Qualifications

License *(specify):*

Certificate *(specify):*

Other Standard *(specify):*
Meet the requirements of Chapter 388-71-0702 through 388-71-0776 WAC
Provider Qualifications

Entity Responsible for Verification:
State/AAA
Frequency of Verification:
upon initial contracting
Annual review per WAC 388-71-0724
Contract compliance monitoring every two years

Appendix C: Participant Services

C-1/C-3: Service Specification

State laws, regulations and policies referenced in the specification are readily available to CMS upon request through the Medicaid agency or the operating agency (if applicable).
Service Type:
Other Service
As provided in 42 CFR §440.180(b)(9), the State requests the authority to provide the following additional service not specified in statute.
Service Title:
Caregiver/Recipient Training Services

Complete this part for a renewal application or a new waiver that replaces an existing waiver. Select one **:**

- ◉ **Service is included in approved waiver. There is no change in service specifications.**
- ○ **Service is included in approved waiver. The service specifications have been modified.**
- ○ **Service is not included in the approved waiver.**

Service Definition *(Scope):*
Recipient training needs are identified in the CARE assessment or in a professional evaluation. This service is provided in accordance with a therapeutic goal in the plan of care and includes for example, adjustment to serious impairment; maintenance or restoration of physical functioning and management of personal care needs, i.e., the development of skills to deal with care providers.

Training services are mandated for each MNIW paid caregiver and provide instruction in either a one-to-one situation or in a group setting. Each caregiver shall receive a two (2) hour orientation and additional twenty eight (28) hours basic training, and ten (10) hours continuing education.

The caregiver training curriculum includes: use of special or adaptive equipment or medically related procedures required to maintain the recipient in the home or community-based setting; and, activities of daily living. In addition, caregiver training teaches critical care giving skills including: client rights and abuse reporting; observation and reporting changes in client condition; infection control, accident prevention, food handling and other information on providing a safe environment; emergency procedures and problem solving.
Specify applicable (if any) limits on the amount, frequency, or duration of this service:
Service provided only as identified in the participant's CARE assessment and plan.

Service Delivery Method *(check each that applies)*:

- ☐ **Participant-directed as specified in Appendix E**
- ☑ **Provider managed**

Specify whether the service may be provided by *(check each that applies)***:**

- ☐ **Legally Responsible Person**
- ☐ **Relative**
- ☐ **Legal Guardian**

Provider Specifications:

Provider Category	Provider Type Title
Individual	Licensed Practical Nurse
Individual	Registered Nurse
Individual	Certified Dietician/nutritionist
Individual	Physical Therapist
Individual	Occupational Therapist
Agency	Home Health Agency
Agency	Home Care Agency
Agency	Community College
Individual	Independent Living Provider
Individual	Pharmacist

Appendix C: Participant Services

C-1/C-3: Provider Specifications for Service

Service Type: Other Service
Service Name: Caregiver/Recipient Training Services

Provider Category:
Individual
Provider Type:
Licensed Practical Nurse
Provider Qualifications
License *(specify):*
LPN license under Chapter 18.79 RCW and Chapter 246-840 WAC

Certificate *(specify):*

Other Standard *(specify):*

Provider Qualifications

Entity Responsible for Verification:
State/AAA

Frequency of Verification:
Upon contracting and per individual licensing schedule thereafter

Appendix C: Participant Services

C-1/C-3: Provider Specifications for Service

Service Type: Other Service
Service Name: Caregiver/Recipient Training Services

Provider Category:
Individual

Provider Type:
Registered Nurse

Provider Qualifications

License *(specify):*
RN license under Chapter 18.79 RCW and Chapter 246-840 WAC

Certificate *(specify):*

Other Standard *(specify):*

Provider Qualifications

Entity Responsible for Verification:
State/AAA

Frequency of Verification:
upon contracting and per individual licensing schedule thereafter

Appendix C: Participant Services

C-1/C-3: Provider Specifications for Service

Service Type: Other Service
Service Name: Caregiver/Recipient Training Services

Provider Category:
Individual

Provider Type:
Certified Dietician/nutritionist

Provider Qualifications

License *(specify):*

Certificate *(specify):*
Dietician and Nutritionist certificate under Chapter 18.138 RCW

Other Standard *(specify):*

Provider Qualifications

Entity Responsible for Verification:
State/AAA

Frequency of Verification:
upon contracting and per individual certification schedule thereafter

Appendix C: Participant Services

C-1/C-3: Provider Specifications for Service

Service Type: Other Service
Service Name: Caregiver/Recipient Training Services

Provider Category:
Individual
Provider Type:
Physical Therapist
Provider Qualifications
License *(specify):*
PT license under Chapter 18.74 RCW
Certificate *(specify):*

Other Standard *(specify):*

Provider Qualifications
Entity Responsible for Verification:
State/AAA
Frequency of Verification:
upon contracting and per individual licensing schedule thereafter

Appendix C: Participant Services

C-1/C-3: Provider Specifications for Service

Service Type: Other Service
Service Name: Caregiver/Recipient Training Services

Provider Category:
Individual
Provider Type:
Occupational Therapist
Provider Qualifications
License *(specify):*
OT license under Chapter 18.59 RCW
Certificate *(specify):*

Other Standard *(specify):*

Provider Qualifications
Entity Responsible for Verification:
State/AAA
Frequency of Verification:
upon contracting and per individual licensing schedule thereafter

Appendix C: Participant Services

C-1/C-3: Provider Specifications for Service

Service Type: Other Service
Service Name: Caregiver/Recipient Training Services

Provider Category:
Agency
Provider Type:
Home Health Agency
Provider Qualifications
License *(specify):*
Home Health Agency license under Chapter 70.127 RCW and Chapter 246-335 WAC
Certificate *(specify):*

Other Standard *(specify):*

Provider Qualifications
Entity Responsible for Verification:
State/AAA
Frequency of Verification:
Upon contracting and per agency licensing schedule thereafter
Contract monitoring every two years

Appendix C: Participant Services

C-1/C-3: Provider Specifications for Service

Service Type: Other Service
Service Name: Caregiver/Recipient Training Services

Provider Category:
Agency
Provider Type:
Home Care Agency
Provider Qualifications
License *(specify):*
Home Care Agency license under Chapter 70.127 RCW and Chapter 246-335 WAC
Certificate *(specify):*

Other Standard *(specify):*

Provider Qualifications
Entity Responsible for Verification:
State/AAA
Frequency of Verification:
upon contracting and per agency licensing schedule thereafter
Contract monitoring every two years

Appendix C: Participant Services

C-1/C-3: Provider Specifications for Service

Service Type: Other Service
Service Name: Caregiver/Recipient Training Services

Provider Category:
Agency
Provider Type:

Community College
Provider Qualifications
License *(specify):*
Certificate *(specify):*
Other Standard *(specify):*
Higher Education Institution conducting programs under Chapter 28B.50.020 RCW
Provider Qualifications
Entity Responsible for Verification:
State/AAA
Frequency of Verification:
upon contracting and as necessary

Appendix C: Participant Services

C-1/C-3: Provider Specifications for Service

Service Type: Other Service
Service Name: Caregiver/Recipient Training Services

Provider Category:
Individual
Provider Type:
Independent Living Provider
Provider Qualifications
License *(specify):*
Certificate *(specify):*
Other Standard *(specify):*
A Bachelor's degree in social work or psychology with two years experience in the coordination or provision of independent living services; or, Two years experience in the coordination or provision of independent living services (e.g. housing, personal assistance services recruitment or management, independent living skills training) in a social service setting under qualified supervision; or, Four years personal experience with a disability.
Provider Qualifications
Entity Responsible for Verification:
State/AAA
Frequency of Verification:
upon contracting and as necessary thereafter

Appendix C: Participant Services

C-1/C-3: Provider Specifications for Service

Service Type: Other Service
Service Name: Caregiver/Recipient Training Services

Provider Category:
Individual
Provider Type:
Pharmacist
Provider Qualifications
License *(specify):*
Licensed per Chapter 18.64 RCW and Chapter 246.863 WAC

Certificate *(specify):*

Other Standard *(specify):*

Provider Qualifications

Entity Responsible for Verification:
State/AAA

Frequency of Verification:
Upon contracting and per individual licensing schedule thereafter

Appendix C: Participant Services

C-1/C-3: Service Specification

State laws, regulations and policies referenced in the specification are readily available to CMS upon request through the Medicaid agency or the operating agency (if applicable).

Service Type:

Other Service

As provided in 42 CFR §440.180(b)(9), the State requests the authority to provide the following additional service not specified in statute.

Service Title:
Community Transition Services

Complete this part for a renewal application or a new waiver that replaces an existing waiver. Select one **:**

- **Service is included in approved waiver. There is no change in service specifications.**
- **Service is included in approved waiver. The service specifications have been modified.**
- **Service is not included in the approved waiver.**

Service Definition *(Scope):*
Community Transitions Services are non-recurring set-up expenses for individuals who are transitioning from an institutional or another provider-operated living arrangement to a living arrangement in a private residence where the person is directly responsible for his or her own living expenses. Allowable expenses are those necessary to enable a person to establish a basic household that do not constitute room and board and may include: (a) security deposits that are required to obtain a lease on an apartment or home; (b) essential household furnishings and moving expense required to occupy and use a community domicile, including furniture, window coverings, food preparation items, and bed/bath linens; (c) set-up fees or deposits for utility or service access, including telephone, electricity, heating and water; (d) services necessary for the individual's health and safety such as pest eradication and one-time cleaning prior to occupancy; (e) moving expenses; (f) necessary home accessibility adaptations; and, (g) activities to assess need, arrange for and procure need resources. This service includes the training of participants and caregivers in the maintainance or upkeep of equipment purchased under the service.

Specify applicable (if any) limits on the amount, frequency, or duration of this service:
Service provided only as identified in the participant's CARE assessment and plan.

Community Transition Services are furnished only to the extent that they are reasonable and necessary as determined through the service plan development process, clearly identified in the service plan and the person is unable to meet such expense or when the services cannot be obtained from other sources. Community Transition Services do not include monthly rental or mortgage expense; room and board; food, regular utility charges; and/or household appliances or items that are intended for purely diversional/recreational purposes.

Community transition services may not be used to furnish or set up living arrangements that are owned or leased by a waiver provider.

Service Delivery Method *(check each that applies)*:

☐ **Participant-directed as specified in Appendix E**

☑ **Provider managed**

Specify whether the service may be provided by *(check each that applies)***:**

☐ **Legally Responsible Person**

☐ **Relative**

☐ **Legal Guardian**

Provider Specifications:

Provider Category	Provider Type Title
Individual	Individual Community Transition Service Provider
Agency	Agency Community Transition Service Provider

Appendix C: Participant Services

C-1/C-3: Provider Specifications for Service

Service Type: Other Service
Service Name: Community Transition Services

Provider Category:
Individual

Provider Type:
Individual Community Transition Service Provider

Provider Qualifications

License *(specify):*

Certificate *(specify):*

Other Standard *(specify):*
The providers of community transition services vary based on the needs of the individual client. Providers must meet any licensing or certification required by State statute or regulation to provide their services. Additionally if the needed service is not one that is regulated, the State will ensure that such services are delivered as specified by waiver beneficiary and detailed in the plan of care.

Provider Qualifications

Entity Responsible for Verification:
State/AAA

Frequency of Verification:
Upon arranging to pay for CTS and as needed

Appendix C: Participant Services

C-1/C-3: Provider Specifications for Service

Service Type: Other Service
Service Name: Community Transition Services

Provider Category:
Agency

Provider Type:
Agency Community Transition Service Provider

Provider Qualifications

License *(specify):*

Certificate *(specify):*

Other Standard *(specify):*
The providers of community transition services vary based on the needs of the individual client. Providers must meet any licensing or certification required by State statute or regulation to provide their services. Additionally if the needed service is not one that is regulated, the State will ensure that such services are delivered as specified by waiver beneficiary and detailed in the plan of care.

Provider Qualifications

Entity Responsible for Verification:
State/AAA
Frequency of Verification:
upon arranging for payment and as necessary thereafter

Appendix C: Participant Services

C-1/C-3: Service Specification

State laws, regulations and policies referenced in the specification are readily available to CMS upon request through the Medicaid agency or the operating agency (if applicable).

Service Type:
Other Service
As provided in 42 CFR §440.180(b)(9), the State requests the authority to provide the following additional service not specified in statute.

Service Title:
Environmental Accessibility Adaptations

Complete this part for a renewal application or a new waiver that replaces an existing waiver. Select one **:**

- (●) **Service is included in approved waiver. There is no change in service specifications.**
- ( ) **Service is included in approved waiver. The service specifications have been modified.**
- ( ) **Service is not included in the approved waiver.**

Service Definition *(Scope):*
Those physical adaptations to the private residence of the participant or the participant's family, required by the participant's service plan, that are necessary to ensure the health, welfare and safety of the participant or that enable the participant to function with greater independence in the home. Such adaptations include the installation of ramps and grab-bars, widening of doorways, modification of bathroom facilities, or the installation of specialized electric and plumbing systems that are necessary to accommodate the medical equipment and supplies that are necessary for the welfare of the participant.Excluded are those adaptations or improvements to the home that are of general utility, and are not of direct medical or remedial benefit to the participant.

Adaptations that add to the total square footage of the home are excluded from this benefit except when necessary to complete an adaptation (e.g., in order to improve entrance/egress to a residence or to configure a bathroom to accommodate a wheelchair).
Environmental Accessability Adaptations includes the performance of
necessary assessments to determine the types of modifications that are necessary.Home modifications may be authorized up to 180 days in advance of the community transition of an institutionalized person.

Specify applicable (if any) limits on the amount, frequency, or duration of this service:
Service provided only as identified in the participant's CARE assessment and plan.

Environmental Accessibility adaptations may not be furnished to adapt living arrangements that are owned or leased by providers of waiver services.

Home modification begun while a person is institutionalized is not considered complete until the date the person leaves the institution and enters the waiver.

Service Delivery Method *(check each that applies)*:

- ☐ **Participant-directed as specified in Appendix E**
- ☑ **Provider managed**

Specify whether the service may be provided by *(check each that applies)***:**

- ☐ **Legally Responsible Person**
- ☐ **Relative**
- ☐ **Legal Guardian**

Provider Specifications:

Provider Category	Provider Type Title
Individual	Home Modifications Contractor
Individual	Volunteer

Appendix C: Participant Services

C-1/C-3: Provider Specifications for Service

Service Type: Other Service
Service Name: Environmental Accessibility Adaptations

Provider Category:
Individual
Provider Type:
Home Modifications Contractor
Provider Qualifications

License *(specify):*

Certificate *(specify):*

Other Standard *(specify):*
Meet the standards of Chapter 18.27 RCW Registration of Contractors
Provider Qualifications

Entity Responsible for Verification:
case manager
Frequency of Verification:
prior to executing contract

Appendix C: Participant Services

C-1/C-3: Provider Specifications for Service

Service Type: Other Service
Service Name: Environmental Accessibility Adaptations

Provider Category:
Individual
Provider Type:
Volunteer
Provider Qualifications

License *(specify):*

Certificate *(specify):*

Other Standard *(specify):*
Must sign confidentiality statement
Knowledge of building codes as applicable to the specific task
Cost must be less than $500 per Chapter 18.27.090(9) RCW

Provider Qualifications

Entity Responsible for Verification:
State/AAA
Frequency of Verification:
Upon contracting for the task

Appendix C: Participant Services

C-1/C-3: Service Specification

State laws, regulations and policies referenced in the specification are readily available to CMS upon request through the Medicaid agency or the operating agency (if applicable).

Service Type:

Other Service

As provided in 42 CFR §440.180(b)(9), the State requests the authority to provide the following additional service not specified in statute.

Service Title:
Home Delivered Meals

Complete this part for a renewal application or a new waiver that replaces an existing waiver. Select one **:**

- (•) **Service is included in approved waiver. There is no change in service specifications.**
- ( ) **Service is included in approved waiver. The service specifications have been modified.**
- ( ) **Service is not included in the approved waiver.**

Service Definition *(Scope):*
Home-delivered meal services provide nutritional balanced meals delivered to the recipient's homes when meal provision is more cost effective than having a personal care provider prepare the meal. These meals shall not replace nor be a substitute for a full day's nutritional regimen but shall provide at least one-third (1/3) of the current recommended dietary allowance as established by the Food and Nutrition Board of the National Academy of Sciences, National Research Council. A unit of service equals one (1) meal. No more than one meal per day will be reimbursed under the waiver.

Home-delivered meals are provided to an individual at home and included in the approved plan of care only when the recipient is homebound, unable to prepare the meal and there is no other person, paid or unpaid, to prepare the meal. When a client's needs cannot be met by a Title III provider due to geographic inaccessibility, special dietary needs, the time of day or week the meal is needed, or existing Title III provider waiting lists, a meal may be provided by restaurants, cafeterias or caterers who comply with Washington State Department of Health and local board of health regulations for food service establishments.

Specify applicable (if any) limits on the amount, frequency, or duration of this service:
-Service provided only as identified in the participant's CARE assessment and plan.
-no more that one meal per day reimbursed under the waiver
-recipient must be homebound, unable to propare the meal and there is no other person paid or unpaid to prepare the meal

Service Delivery Method *(check each that applies)*:

- [ ] **Participant-directed as specified in Appendix E**
- [x] **Provider managed**

Specify whether the service may be provided by *(check each that applies)*:

- ☐ **Legally Responsible Person**
- ☐ **Relative**
- ☐ **Legal Guardian**

Provider Specifications:

Provider Category	Provider Type Title
Agency	Food Service Vendor

Appendix C: Participant Services

C-1/C-3: Provider Specifications for Service

Service Type: Other Service
Service Name: Home Delivered Meals

Provider Category:
Agency
Provider Type:
Food Service Vendor
Provider Qualifications

License *(specify):*

Certificate *(specify):*

Other Standard *(specify):*
Title III Home delivered nutrition program standards and Chapter 246-215 WAC (food service) Provider Qualifications

Entity Responsible for Verification:
AAA
Frequency of Verification:
Upon contracting and as necessary thereafter

Appendix C: Participant Services

C-1/C-3: Service Specification

State laws, regulations and policies referenced in the specification are readily available to CMS upon request through the Medicaid agency or the operating agency (if applicable).
Service Type:
Other Service
As provided in 42 CFR §440.180(b)(9), the State requests the authority to provide the following additional service not specified in statute.
Service Title:
In Home Nurse Delegation

Complete this part for a renewal application or a new waiver that replaces an existing waiver. Select one **:**

- ◉ **Service is included in approved waiver. There is no change in service specifications.**
- ○ **Service is included in approved waiver. The service specifications have been modified.**
- ○ **Service is not included in the approved waiver.**

Service Definition *(Scope):*

Nurse Delegation Services-A registered nurse delegator assesses a client for program suitability; and teaches, evaluates competency and supervises the performance of a nursing assistant. The nursing assistant has met additional educational requirements performs the delegated nursing tasks for a client. These tasks may include administration of non-injectable medications, blood glucose monitoring, ostomy care, simple wound care, straight catheterization or other tasks determined appropriate by the delegating nurse.
Specify applicable (if any) limits on the amount, frequency, or duration of this service:
Service provided only as identified in the participant's CARE assessment and plan.

The following tasks CAN NOT be delegated: Injections, central lines, sterile procedures, and tasks that require nursing judgement.

Service provided per Chapter 18.79.260 RCW

Service Delivery Method *(check each that applies)*:

- ☐ **Participant-directed as specified in Appendix E**
- ☑ **Provider managed**

Specify whether the service may be provided by *(check each that applies)***:**

- ☐ **Legally Responsible Person**
- ☐ **Relative**
- ☐ **Legal Guardian**

Provider Specifications:

Provider Category	Provider Type Title
Individual	Registered Nurse
Agency	Home Health Agency

Appendix C: Participant Services

C-1/C-3: Provider Specifications for Service

Service Type: Other Service
Service Name: In Home Nurse Delegation

Provider Category:
Individual
Provider Type:
Registered Nurse
Provider Qualifications
License *(specify):*
licensed under Chapter 18.79.040
Certificate *(specify):*
Other Standard *(specify):*
Provider Qualifications
Entity Responsible for Verification:
State or AAA
Frequency of Verification:
Upon contracting and per individual licensing schedule

Appendix C: Participant Services

C-1/C-3: Provider Specifications for Service

Service Type: Other Service
Service Name: In Home Nurse Delegation

Provider Category:
Agency
Provider Type:
Home Health Agency
Provider Qualifications
License *(specify):*
Licensed under Chapter 70.127 RCW
Certificate *(specify):*

Other Standard *(specify):*
Individual RNs employed by the agency must be licensed under Chapter 18.79 RCW and Chapter 246-840 WAC.
Provider Qualifications
Entity Responsible for Verification:
State/AAA
Frequency of Verification:
Upon contracting
Contract monitoring every two years

Appendix C: Participant Services

C-1/C-3: Service Specification

State laws, regulations and policies referenced in the specification are readily available to CMS upon request through the Medicaid agency or the operating agency (if applicable).
Service Type:
Other Service
As provided in 42 CFR §440.180(b)(9), the State requests the authority to provide the following additional service not specified in statute.
Service Title:
Personal Emergency Response

Complete this part for a renewal application or a new waiver that replaces an existing waiver. Select one **:**

- (●) **Service is included in approved waiver. There is no change in service specifications.**
- ( ) **Service is included in approved waiver. The service specifications have been modified.**
- ( ) **Service is not included in the approved waiver.**

Service Definition *(Scope):*
PERS is an electronic device that enables waiver participants to secure help in an emergency. The participant may also wear a portable "help" button to allow for mobility. The system is programmed to signal a response center once a "help" button is activated. Some PERS systems can also include medication reminders.The response center is staffed by trained professionals.

PERS services are limited to those individuals who live alone or with others who cannot summon help in an emergency , or who are alone or with others who cannot summon help in an emergency for significant parts of the day, and have no regular caregiver for extended periods of time, and who would otherwise require extensive routine supervision.

1. All PERS equipment vendors must provide equipment approved by the Federal Communications Commission and the equipment must meet the Underwriters Laboratories, Inc., (UL) standard for home health care signaling equipment. The UL listing mark on the equipment will be accepted as evidence of the equipment's compliance with

such standard.

2. The emergency response activator must be able to be activated by breath, by touch, or some other means and must be usable by persons who are visually or hearing impaired or physically disabled.

3. The emergency response communicator must not interfere with normal telephone use. The communicator must be capable of operating without external power during a power failure at the recipient's home in accordance with UL requirements for home health care signaling equipment with stand-by capability.

Specify applicable (if any) limits on the amount, frequency, or duration of this service:

Service provided only as identified in the participant's CARE assessment and plan.

PERS cannot be used solely for the purpose of medication reminders.

The participant must live alone or with others who cannot summon help in an emergency or must be alone with no regular caregiver for extended periods of time.

Service Delivery Method *(check each that applies)*:

- ☐ **Participant-directed as specified in Appendix E**
- ☑ **Provider managed**

Specify whether the service may be provided by *(check each that applies)***:**

- ☐ **Legally Responsible Person**
- ☐ **Relative**
- ☐ **Legal Guardian**

Provider Specifications:

Provider Category	Provider Type Title
Agency	Electronic Communication Equipment and Monitoring Company

Appendix C: Participant Services

C-1/C-3: Provider Specifications for Service

Service Type: Other Service
Service Name: Personal Emergency Response

Provider Category:

Agency

Provider Type:

Electronic Communication Equipment and Monitoring Company

Provider Qualifications

License *(specify):*

Certificate *(specify):*

Other Standard *(specify):*

The monitoring agency must be capable of simultaneously responding to multiple signals for help from clients' PERS equipment. The monitoring agency's equipment must include a primary receiver, a stand-by information retrieval system and a separate telephone service, a stand-by receiver, a stand-by back up power supply, and a telephone line monitor. The primary receiver and back-up receiver must be independent and interchangeable. The clock printer must print out the time and date of the emergency signal, the PERS client's Medical identification code (PIC) and the emergency code that indicates whether the signal is active, passive, or a responder test. The telephone line monitor must give visual and audible signals when an incoming telephone line is disconnected for more than 10 seconds. The monitoring agency must maintain detailed technical and operations manuals that describe PERS elements including PERS equipment installation, functioning and testing; emergency response protocols; and record keeping and reporting procedures.

Provider Qualifications

Entity Responsible for Verification:
State
Frequency of Verification:
Every two years

Appendix C: Participant Services

C-1/C-3: Service Specification

State laws, regulations and policies referenced in the specification are readily available to CMS upon request through the Medicaid agency or the operating agency (if applicable).

Service Type:

Other Service

As provided in 42 CFR §440.180(b)(9), the State requests the authority to provide the following additional service not specified in statute.

Service Title:
Skilled Nursing

Complete this part for a renewal application or a new waiver that replaces an existing waiver. Select one **:**

- (•) **Service is included in approved waiver. There is no change in service specifications.**
- ( ) **Service is included in approved waiver. The service specifications have been modified.**
- ( ) **Service is not included in the approved waiver.**

Service Definition *(Scope):*
Services listed in the service plan that are within the scope of the State's Nurse Practice Act and are provided by a registered professional nurse, or licensed practical nurse under the supervision of a registered nurse, licensed to practice in the State. Skilled nursing services under the waiver differ in nature, scope, supervision arrangements, or provider type (including provider training and qualifications) from skilled nursing services in the State plan. Under the state plan, skilled nursing is intended for short-term, intermittant treatment of acute conditions or exacerbation of a chronic condition. The waiver skilled nursing service is used for treatment of chronic, stable,long-term conditions that cannot be delegated or self-directed.

Specify applicable (if any) limits on the amount, frequency, or duration of this service:
Service provided only as identified in the participant's CARE assessment and plan.

Service Delivery Method *(check each that applies)*:

- [ ] **Participant-directed as specified in Appendix E**
- [x] **Provider managed**

Specify whether the service may be provided by *(check each that applies)***:**

- [ ] **Legally Responsible Person**
- [ ] **Relative**
- [ ] **Legal Guardian**

Provider Specifications:

Provider Category	Provider Type Title
Individual	Registered Nurse
Individual	Licensed Practical Nurse
Agency	Home Health Agency

Appendix C: Participant Services

C-1/C-3: Provider Specifications for Service

Service Type: Other Service
Service Name: Skilled Nursing

Provider Category:
Individual
Provider Type:
Registered Nurse
Provider Qualifications
License *(specify):*
Licensed under Chapter 18.79 RCW and Chapter 246-840 WAC
Certificate *(specify):*
Other Standard *(specify):*
Provider Qualifications
Entity Responsible for Verification:
State or AAA prior to contracting
Frequency of Verification:
Prior to contracting and on individual license renewal schedule

Appendix C: Participant Services

C-1/C-3: Provider Specifications for Service

Service Type: Other Service
Service Name: Skilled Nursing

Provider Category:
Individual
Provider Type:
Licensed Practical Nurse
Provider Qualifications
License *(specify):*
Licensed under Chapter 18.79 RCW and Chapter 246-840 WAC
Certificate *(specify):*
Other Standard *(specify):*
Provider Qualifications
Entity Responsible for Verification:
State or AAA
Frequency of Verification:
Prior to contracting and per individual licensing schedule

Appendix C: Participant Services

C-1/C-3: Provider Specifications for Service

Service Type: Other Service
Service Name: Skilled Nursing

Provider Category:

Agency

Provider Type:
Home Health Agency
Provider Qualifications
License *(specify):*
License under Chapter 70.127 RCW
Certificate *(specify):*

Other Standard *(specify):*
Individual RNs and LPNs employed by the agency must be licensed under Chapter 18.79 RCW and Chapter 246-840 WAC.
Provider Qualifications
Entity Responsible for Verification:
State/AAA
Frequency of Verification:
upon contracting and per licensing schedule

Appendix C: Participant Services

C-1/C-3: Service Specification

State laws, regulations and policies referenced in the specification are readily available to CMS upon request through the Medicaid agency or the operating agency (if applicable).
Service Type:
Other Service
As provided in 42 CFR §440.180(b)(9), the State requests the authority to provide the following additional service not specified in statute.
Service Title:
Specialized Medical Equipment and Supplies

Complete this part for a renewal application or a new waiver that replaces an existing waiver. Select one **:**

- (•) **Service is included in approved waiver. There is no change in service specifications.**
- ( ) **Service is included in approved waiver. The service specifications have been modified.**
- ( ) **Service is not included in the approved waiver.**

Service Definition *(Scope):*
Specialized medical equipment and supplies to include devices, controls, or appliances, specified in the plan of care, which enable individuals to increase their abilities to perform activities of daily living, or to perceive, control, or communicate with he environment in which they live.

This service also includes items necessary for life support, ancillary supplies and equipment necessary to the proper functioning of such items, and durable and non-durable medical equipment not available under the Medicaid State Plan. Items reimbursed with waiver funds shall be in addition to any medical equipment and supplies furnished under the State plan and shall exclude those items which are not of direct medical or remedial benefit to the individual. All items shall meet applicable standards of manufacture, design and installation.

This service also includes maintainence and upkeep of items covered under the service and training for the participant/caregivers in the operation and maintainance of the item.
Specify applicable (if any) limits on the amount, frequency, or duration of this service:
Service provided only as identified in the participant's CARE assessment and plan. Items reimbursed with waiver funds shall be in addition to any medical equipment and supplies furnished under the State plan and shall exclude those items, which are not of direct medical or remedial benefit to the individual.

Service Delivery Method *(check each that applies)*:

☐ **Participant-directed as specified in Appendix E**

☑ **Provider managed**

Specify whether the service may be provided by *(check each that applies)***:**

☐ **Legally Responsible Person**

☐ **Relative**

☐ **Legal Guardian**

Provider Specifications:

Provider Category	Provider Type Title
Agency	Medical Equipement and Supply Contractor

Appendix C: Participant Services

C-1/C-3: Provider Specifications for Service

Service Type: Other Service
Service Name: Specialized Medical Equipment and Supplies

Provider Category:
Agency
Provider Type:
Medical Equipement and Supply Contractor
Provider Qualifications
License *(specify):*
Have a State contract as a Title XIX vendor
Certificate *(specify):*

Other Standard *(specify):*

Provider Qualifications
Entity Responsible for Verification:
State/AAA
Frequency of Verification:
upon purchase of specialized equipment and as necessary thereafter

Appendix C: Participant Services

C-1/C-3: Service Specification

State laws, regulations and policies referenced in the specification are readily available to CMS upon request through the Medicaid agency or the operating agency (if applicable).
Service Type:
Other Service
As provided in 42 CFR §440.180(b)(9), the State requests the authority to provide the following additional service not specified in statute.
Service Title:
Transportation

Complete this part for a renewal application or a new waiver that replaces an existing waiver. Select one **:**

◉ **Service is included in approved waiver. There is no change in service specifications.**

○ **Service is included in approved waiver. The service specifications have been modified.**

○ **Service is not included in the approved waiver.**

Service Definition *(Scope):*
Service offered in order to enable waiver participants to gain access to waiver and other community services, activities and resources, as specified by the service plan. This service is offered in addition to medical transportation required under 42 CFR §431.53 and transportation services under the State plan, defined at 42 CFR §440.170(a) (if applicable), and does not replace them. Transportation services under the waiver are offered in accordance with the participant's service plan. Whenever possible, family, neighbors, friends, or community agencies which can provide this service without charge are utilized.
Specify applicable (if any) limits on the amount, frequency, or duration of this service:

Service Delivery Method *(check each that applies)*:

☐ **Participant-directed as specified in Appendix E**
☑ **Provider managed**

Specify whether the service may be provided by *(check each that applies)***:**
☐ **Legally Responsible Person**
☐ **Relative**
☐ **Legal Guardian**

Provider Specifications:

Provider Category	Provider Type Title
Individual	Taxi
Agency	Public Transit
Individual	Volunteer

Appendix C: Participant Services

C-1/C-3: Provider Specifications for Service

Service Type: Other Service
Service Name: Transportation

Provider Category:
Individual
Provider Type:
Taxi
Provider Qualifications
License *(specify):*
Certificate *(specify):*
Other Standard *(specify):*
Standards are the same as those applied to vendors who provide access to state plan medical services
Provider Qualifications
Entity Responsible for Verification:
State or AAA
Frequency of Verification:
prior to contracting

Appendix C: Participant Services

C-1/C-3: Provider Specifications for Service

Service Type: Other Service
Service Name: Transportation

Provider Category:
Agency
Provider Type:
Public Transit
Provider Qualifications
License *(specify):*

Certificate *(specify):*

Other Standard *(specify):*
Standards are the same as those applied to vendors who provide access to state plan medical services Provider Qualifications
Entity Responsible for Verification:
State/AAA
Frequency of Verification:
prior to contracting

Appendix C: Participant Services

C-1/C-3: Provider Specifications for Service

Service Type: Other Service
Service Name: Transportation

Provider Category:
Individual
Provider Type:
Volunteer
Provider Qualifications
License *(specify):*

Certificate *(specify):*

Other Standard *(specify):*
Standards are the same as those applied to vendors who provide access to state plan medical services Provider Qualifications
Entity Responsible for Verification:
State/AAA
Frequency of Verification:
Prior to contracting

Appendix C: Participant Services

C-1: Summary of Services Covered (2 of 2)

b. Alternate Provision of Case Management Services to Waiver Participants. When case management is not a

covered waiver service, indicate how case management is furnished to waiver participants (*select one*):

- **Not applicable** - Case management is not furnished as a distinct activity to waiver participants.
- **Applicable** - Case management is furnished as a distinct activity to waiver participants.
  Check each that applies
  - **As a Medicaid State plan service under §1915(g)(1) of the Act (Targeted Case Management).** *Complete item C-1-c.*
  - **As an administrative activity.** *Complete item C-1-c.*
- **None of the above apply** (i.e., case management is furnished as a waiver service)

c. Delivery of Case Management Services. Specify the entity or entities that conduct case management functions on behalf of waiver participants:

Case management is provided by State case managers and Area Agency on Aging case managers as an administrative activity.

Appendix C: Participant Services

C-2: General Service Specifications (1 of 3)

a. Criminal History and/or Background Investigations. Specify the State's policies concerning the conduct of criminal history and/or background investigations of individuals who provide waiver services (select one):

- **No. Criminal history and/or background investigations are not required.**
- **Yes. Criminal history and/or background investigations are required.**

Specify: (a) the types of positions (e.g., personal assistants, attendants) for which such investigations must be conducted; (b) the scope of such investigations (e.g., state, national); and, (c) the process for ensuring that mandatory investigations have been conducted. State laws, regulations and policies referenced in this description are available to CMS upon request through the Medicaid or the operating agency (if applicable):

(a) the types of positions (e.g., personal assistants, attendants) for which such investigations must be conducted;

Personal care providers (agency or individual), case managers, LPN, RN, Nursing Assistant, Certified Dietician, Physical Therapist, Occupational Therapist, and any waiver provider who has unsupervised access to a vulnerable adult.

(b) the scope of such investigations (e.g., state, national); and,

The State has a three part background check that includes (1) immediate information about convictions for disqualifying crimes{state} (2) more comprehensive criminal history information including aliases, as well as information about persons who are on a state registry for findings of abuse, neglect, abandonment or exploitation against a minor or vulnerable adult.{state} (3) If the provider has lived in Washington State less than three years, a fingerprint-based check.{national}

(c) the process for ensuring that mandatory investigations have been conducted.

Contracts cannot be executed and providers cannot be paid without evidence of complete background check which includes abuse registry screening.

Background checks are regulated under the following Washington Administrative Code:
388-06-0010 What is the purpose of this chapter?
DEFINITIONS
388-06-0020 What definitions apply to WAC 388-06-0100 through 388-06-0260 of this chapter?
388-06-0100 Why are background checks done?
388-06-0110 Who must have background checks?

388-06-0120 Who is not affected by this chapter?
388-06-0130 Does the background check process apply to new and renewal licenses, certification, contracts, and authorizations to have unsupervised access to children or individuals with a developmental disability?
388-06-0140 What happens if I don't comply with the background check requirement?
388-06-0150 What does the background check cover?
388-06-0160 Who pays for the background check?
388-06-0170 Will a criminal conviction permanently prohibit me from being licensed, contracted, or authorized to have unsupervised access to children or to individuals with developmental disability?
388-06-0180 Are there other criminal convictions that will prohibit me from working with children or individuals with a developmental disability?
388-06-0190 If I have a conviction, may I ever have unsupervised access to children or individuals with a developmental disability?
388-06-0200 Will I be disqualified if there are pending criminal charges on my background check?
388-06-0210 Will you license, contract, or authorize me to have unsupervised access to children or individuals with a developmental disability if my conviction has been expunged, or vacated from my record or I have been pardoned for a crime?
388-06-0220 How will I know if I have not been disqualified by the background check?
388-06-0230 How will I know if I have been disqualified by the background check?
388-06-0240 What may I do if I disagree with the department's decision to deny me a license, certification, contract, or authorization based on the results of the background check?
388-06-0250 Is the background check information released to my employer or prospective employer?
388-06-0260 May I receive a copy of my criminal background check results?
ONE HUNDRED AND TWENTY-DAY PROVISIONAL HIRE -- PENDING FBI BACKGROUND CHECK RESULTS
388-06-0500 What is the purpose of the one hundred twenty-day provisional hire?
388-06-0510 What definitions apply to one hundred twenty-day provisional hires?
388-06-0520 Who is responsible for approving the one hundred twenty-day provisional hire?
388-06-0525 When are individuals eligible for the one hundred twenty-day provisional hire?
388-06-0530 When does the one hundred twenty-day provisional hire begin?
388-06-0535 Who approves one hundred twenty-day provisional hire extensions?
388-06-0540 Are there instances when the one hundred twenty-day provisional hire is not available?
388-71-01280 Does the department disclose information about final findings of abuse, abandonment, neglect and financial exploitation?
388-71-0513 Is a background check required of a home care agency provider?
388-71-0546 When can the department, AAA, or managed care entity reject the client's choice of an individual provider?
388-71-0551 When can the department, AAA, or managed care entity terminate or summarily suspend an individual provider's contract?
388-71-0556 When can the department, AAA, or managed care entity otherwise terminate an individual provider's contract?

b. Abuse Registry Screening. Specify whether the State requires the screening of individuals who provide waiver services through a State-maintained abuse registry (select one):

- ○ **No. The State does not conduct abuse registry screening.**
- ◉ **Yes. The State maintains an abuse registry and requires the screening of individuals through this registry.**

Specify: (a) the entity (entities) responsible for maintaining the abuse registry; (b) the types of positions for which abuse registry screenings must be conducted; and, (c) the process for ensuring that mandatory screenings have been conducted. State laws, regulations and policies referenced in this description are available to CMS upon request through the Medicaid agency or the operating agency (if applicable):

(a)The state maintains the abuse registry
(b)Personal care providers (agency or individual), case managers, LPN, RN, Nursing Assistant, Certified Dietician, Physical Therapist, Occupational Therapist, and any waiver provider who has unsupervised access to a vulnerable adult
(c)Contracts cannot be executed and providers cannot be paid without evidence of complete background check which includes abuse registry screening.

Background checks (which include abuse registry screening) are regulated under the following Washington

Administrative Code:
388-06-0010 What is the purpose of this chapter?
DEFINITIONS
388-06-0020 What definitions apply to WAC 388-06-0100 through 388-06-0260 of this chapter?
388-06-0100 Why are background checks done?
388-06-0110 Who must have background checks?
388-06-0120 Who is not affected by this chapter?
388-06-0130 Does the background check process apply to new and renewal licenses, certification, contracts, and authorizations to have unsupervised access to children or individuals with a developmental disability?
388-06-0140 What happens if I don't comply with the background check requirement?
388-06-0150 What does the background check cover?
388-06-0160 Who pays for the background check?
388-06-0170 Will a criminal conviction permanently prohibit me from being licensed, contracted, or authorized to have unsupervised access to children or to individuals with developmental disability?
388-06-0180 Are there other criminal convictions that will prohibit me from working with children or individuals with a developmental disability?
388-06-0190 If I have a conviction, may I ever have unsupervised access to children or individuals with a developmental disability?
388-06-0200 Will I be disqualified if there are pending criminal charges on my background check?
388-06-0210 Will you license, contract, or authorize me to have unsupervised access to children or individuals with a developmental disability if my conviction has been expunged, or vacated from my record or I have been pardoned for a crime?
388-06-0220 How will I know if I have not been disqualified by the background check?
388-06-0230 How will I know if I have been disqualified by the background check?
388-06-0240 What may I do if I disagree with the department's decision to deny me a license, certification, contract, or authorization based on the results of the background check?
388-06-0250 Is the background check information released to my employer or prospective employer?
388-06-0260 May I receive a copy of my criminal background check results?
ONE HUNDRED AND TWENTY-DAY PROVISIONAL HIRE -- PENDING FBI BACKGROUND CHECK RESULTS
388-06-0500 What is the purpose of the one hundred twenty-day provisional hire?
388-06-0510 What definitions apply to one hundred twenty-day provisional hires?
388-06-0520 Who is responsible for approving the one hundred twenty-day provisional hire?
388-06-0525 When are individuals eligible for the one hundred twenty-day provisional hire?
388-06-0530 When does the one hundred twenty-day provisional hire begin?
388-06-0535 Who approves one hundred twenty-day provisional hire extensions?
388-06-0540 Are there instances when the one hundred twenty-day provisional hire is not available?
388-71-01280 Does the department disclose information about final findings of abuse, abandonment, neglect and financial exploitation?
388-71-0513 Is a background check required of a home care agency provider?
388-71-0546 When can the department, AAA, or managed care entity reject the client's choice of an individual provider?
388-71-0551 When can the department, AAA, or managed care entity terminate or summarily suspend an individual provider's contract?
388-71-0556 When can the department, AAA, or managed care entity otherwise terminate an individual provider's contract?

Appendix C: Participant Services

C-2: General Service Specifications (2 of 3)

c. Services in Facilities Subject to §1616(e) of the Social Security Act. *Select one:*

- **No. Home and community-based services under this waiver are not provided in facilities subject to §1616 (e) of the Act.**
- **Yes. Home and community-based services are provided in facilities subject to §1616(e) of the Act. The standards that apply to each type of facility where waiver services are provided are available to CMS upon request through the Medicaid agency or the operating agency (if applicable).**

Appendix C: Participant Services

C-2: General Service Specifications (3 of 3)

d. Provision of Personal Care or Similar Services by Legally Responsible Individuals. A legally responsible individual is any person who has a duty under State law to care for another person and typically includes: (a) the parent (biological or adoptive) of a minor child or the guardian of a minor child who must provide care to the child or (b) a spouse of a waiver participant. Except at the option of the State and under extraordinary circumstances specified by the State, payment may not be made to a legally responsible individual for the provision of personal care or similar services that the legally responsible individual would ordinarily perform or be responsible to perform on behalf of a waiver participant. *Select one*:

- **No. The State does not make payment to legally responsible individuals for furnishing personal care or similar services.**
- **Yes. The State makes payment to legally responsible individuals for furnishing personal care or similar services when they are qualified to provide the services.**

Specify: (a) the legally responsible individuals who may be paid to furnish such services and the services they may provide; (b) State policies that specify the circumstances when payment may be authorized for the provision of ***extraordinary care*** by a legally responsible individual and how the State ensures that the provision of services by a legally responsible individual is in the best interest of the participant; and, (c) the controls that are employed to ensure that payments are made only for services rendered. *Also, specify in Appendix C-1/C-3 the personal care or similar services for which payment may be made to legally responsible individuals under the State policies specified here.*

e. Other State Policies Concerning Payment for Waiver Services Furnished by Relatives/Legal Guardians. Specify State policies concerning making payment to relatives/legal guardians for the provision of waiver services over and above the policies addressed in Item C-2-d. *Select one*:

- **The State does not make payment to relatives/legal guardians for furnishing waiver services.**
- **The State makes payment to relatives/legal guardians under specific circumstances and only when the relative/guardian is qualified to furnish services.**

Specify the specific circumstances under which payment is made, the types of relatives/legal guardians to whom payment may be made, and the services for which payment may be made. Specify the controls that are employed to ensure that payments are made only for services rendered. *Also, specify in Appendix C-1/C-3 each waiver service for which payment may be made to relatives/legal guardians.*

- **Relatives/legal guardians may be paid for providing waiver services whenever the relative/legal guardian is qualified to provide services as specified in Appendix C-1/C-3.**

Specify the controls that are employed to ensure that payments are made only for services rendered.

A participant may choose a relative/legal guardian to provide personal care except a spouse/married or legally separated. (This waiver is for adults only) Providers, regardless of relationship to the participant, must meet all specified qualifications and must have a properly executed provider agreement. When the participant is unable to supervise providers, case managers are instructed to identify a third party to provide supervision and monitor the best interests of the participant (long term care manual chapter 3).

Accountability systems regarding receipt and payment for waiver services provided by non-relative providers are applicable to relative providers.

Participants with relative/legal guardian providers living in the same residence have base hours adjusted to

support shared living circumstances. CARE determines the adjustment by placing a numeric value on the amount of assistance available to meet the client's needs and reduces the base hours assigned to the classification group using assigned values for each specific ADL and IADL.

Payment for services is processed by the Department. DSHS maintains data on the waiver participant including participant name, birth date, social security number and case number. The participant data is associated with the provider name, provider payment identification number, waiver service begin and end dates, rates and authorization information. An invoice from an authorized provider is the basis for payment of waiver services which have been provided. Each service is shown on an invoice one time each month it was authorized as the month ends. A service will not be shown on an invoice a second time unless the case manager re-authorizes payment. The signed invoice is verification the service has actually been provided. Payments are made directly to the service provider

Payment for services identified in the care plan will be authorized when the following are satisfied:
1. Categorical relatedness and financial eligibility are approved
2. The participant is eligible for nursing facility level of care and is, or likely to be institutionalized
3. The care plan has been approved by the participant and consultant
4. The service provider is qualified

As with providers who are not related to the participant, per WAC 388-71-0551, the department or contracted AAA may take action to terminate an individual provider's contract if the provider's inadequate performance or inability to deliver quality care is jeopardizing the participant's health, safety, or well-being. Examples of circumstances indicating jeopardy to the client could include, without limitation:

(1) Domestic violence or abuse, neglect, abandonment, or exploitation of a minor or vulnerable adult;

(2) Using or being under the influence of alcohol or illegal drugs during working hours;

(3) Other behavior directed toward the client or other persons involved in the client's life that places the client at risk of harm;

(4) A report from the client's health care provider that the client's health is negatively affected by inadequate care;

(5) A complaint from the client or client's representative that the client is not receiving adequate care;

(6) The absence of essential interventions identified in the service plan, such as medications or medical supplies

○ **Other policy.**

Specify:

f. Open Enrollment of Providers. Specify the processes that are employed to assure that all willing and qualified providers have the opportunity to enroll as waiver service providers as provided in 42 CFR §431.51:

Individual providers of personal care who meet published qualifications can enroll any time. Participants who use individual providers of personal care services can choose their provider. If a participant chooses a provider who is not enrolled, ADSA and AAA case managers assist the proposed provider with enrollment by providing background checks, training and contracting. Any willing and qualified provider has the opportunity to enroll any time. The state maintains an open registry of qualified providers. Qualifications are published in WAC and are available to the public via web access and by hard copy upon request.

For all other waiver services, the state establishes qualifications and offers the opportunity for any willing provider to demonstrate qualifications and enroll via a periodic issuance of Requests for Qualifications. Any provider who meets qualifications and is willing to contract must be contracted per policy. If there are access problems identified in any area of the state, the local area must immediately seek out and enroll qualified providers to address the access problem.

Appendix C: Participant Services

C-3: Waiver Services Specifications

Section C-3 'Service Specifications' is incorporated into Section C-1 'Waiver Services.'

Appendix C: Participant Services

C-4: Additional Limits on Amount of Waiver Services

a. Additional Limits on Amount of Waiver Services. Indicate whether the waiver employs any of the following additional limits on the amount of waiver services (*select one*).

- (●) **Not applicable** - The State does not impose a limit on the amount of waiver services except as provided in Appendix C-3.
- ( ) **Applicable** - The State imposes additional limits on the amount of waiver services.

When a limit is employed, specify: (a) the waiver services to which the limit applies; (b) the basis of the limit, including its basis in historical expenditure/utilization patterns and, as applicable, the processes and methodologies that are used to determine the amount of the limit to which a participant's services are subject; (c) how the limit will be adjusted over the course of the waiver period; (d) provisions for adjusting or making exceptions to the limit based on participant health and welfare needs or other factors specified by the state; (e) the safeguards that are in effect when the amount of the limit is insufficient to meet a participant's needs; (f) how participants are notified of the amount of the limit. (*check each that applies*)

- ☐ **Limit(s) on Set(s) of Services.** There is a limit on the maximum dollar amount of waiver services that is authorized for one or more sets of services offered under the waiver.
  Furnish the information specified above.

- ☐ **Prospective Individual Budget Amount.** There is a limit on the maximum dollar amount of waiver services authorized for each specific participant.
  Furnish the information specified above.

- ☐ **Budget Limits by Level of Support.** Based on an assessment process and/or other factors, participants are assigned to funding levels that are limits on the maximum dollar amount of waiver services.
  Furnish the information specified above.

- ☐ **Other Type of Limit.** The State employs another type of limit.
  Describe the limit and furnish the information specified above.

Appendix D: Participant-Centered Planning and Service Delivery

D-1: Service Plan Development (1 of 8)

State Participant-Centered Service Plan Title:
Comprehensive Assessment Reporting Evaluation (CARE) Plan

a. Responsibility for Service Plan Development. Per 42 CFR §441.301(b)(2), specify who is responsible for the development of the service plan and the qualifications of these individuals *(select each that applies):*

- [x] **Registered nurse, licensed to practice in the State**
- [ ] **Licensed practical or vocational nurse, acting within the scope of practice under State law**
- [ ] **Licensed physician (M.D. or D.O)**
- [ ] **Case Manager** (qualifications specified in Appendix C-1/C-3)
- [x] **Case Manager** (qualifications not specified in Appendix C-1/C-3).

Specify qualifications:

RN: licensed under Chapter 18.79 RCW

Case Manager:
In addition to meeting the following minimum qualifications, staff must pass a background check prior to being hired and receive mandatory training prior to completing any evaluations.

Service plans are developed by case managers who can be a Registered Nurse (licensed in the State)or a Social Worker. For social workers, minimum qualifications are as follows:

A Master's degree in social services, human services, behavioral sciences, or an allied field and two years of paid social service experience equivalent to a Social Worker 2.

OR

A Bachelor's degree in social services, human services, behavioral sciences, or an allied field, and three years of paid social service experience performing functions equivalent to a Social Worker 2.

NOTE: A two year Master's degree in one of the above fields that included a practicum will be substituted for one year of paid social service experience.

NOTE: Employees must successfully complete the formal training course sponsored by their division within one year of their appointment.

NOTE: Equivalent social service experience would include the previous classes of Caseworker 3 or higher.

OR

For Promotion Only: A Bachelor's degree and three years of experience as a Caseworker 3, Social Worker 1A or B, Social Worker 2, Casework Supervisor Trainee, Casework Supervisor, Juvenile Rehabilitation Supervisor 1 or 2, or Juvenile Rehabilitation Counselor 2 in State service.

Job classification discriptions are available from the Medicaid agency.

- [ ] **Social Worker.**

Specify qualifications:

- [ ] **Other**

Specify the individuals and their qualifications:

Appendix D: Participant-Centered Planning and Service Delivery

D-1: Service Plan Development (2 of 8)

b. Service Plan Development Safeguards. *Select one:*

- **Entities and/or individuals that have responsibility for service plan development may not provide other direct waiver services to the participant.**
- **Entities and/or individuals that have responsibility for service plan development may provide other direct waiver services to the participant.**

  The State has established the following safeguards to ensure that service plan development is conducted in the best interests of the participant. *Specify:*

Appendix D: Participant-Centered Planning and Service Delivery

D-1: Service Plan Development (3 of 8)

c. Supporting the Participant in Service Plan Development. Specify: (a) the supports and information that are made available to the participant (and/or family or legal representative, as appropriate) to direct and be actively engaged in the service plan development process and (b) the participant's authority to determine who is included in the process.

Case managers review the "Client's Rights and Responsibilities (DSHS 16-172)" document with clients that outlines their right to participate in the development of their plan of care and ensure that their preferences and the services they wish to receive are included in their plan of care. The Client's Rights are:

As a client of Aging and Disability Services Administration, you have a right to:
• Be treated with dignity, respect and without discrimination;
• Not be abused, neglected, financially exploited, abandoned;
• Have your property treated with respect;
• Not answer questions, turn down services, and not accept case management services you do not want to receive. However, it may not be possible for Aging and Disability
Services Administration to offer some services if you do not give enough information;
• Be told about all services you can receive and make choices about services you want or don't want;
• Have information about you kept private within the limits of the laws and DSHS regulations;
• Be told in writing of agency decisions and receive a copy of your care plan;
• Not be forced to answer questions or do something you don't want to;
• Talk with your social service worker's supervisor if you and your social service worker do not agree;
• Request a fair hearing;
• Have interpreter services provided to you free of charge if you cannot speak or understand English well;
• Take part in and have your wishes included in planning your care;
• Choose, fire, or change a qualified provider you want; and
• Receive the results of the background check for any individual provider you choose.

The "Medicaid and Long Term Care Services for Adults (DSHS 22-619)" brochure is given to all new clients at initial assessment. This document outlines Medicaid eligibility and long term care services available.

Service plan development always includes the client and their legal representative (if applicable). Clients may include any other individuals of their choice to participate. ADSA encourages clients to include family and other informal supports as appropriate to the client's situation.

Appendix D: Participant-Centered Planning and Service Delivery

D-1: Service Plan Development (4 of 8)

d. Service Plan Development Process. In four pages or less, describe the process that is used to develop the participant-centered service plan, including: (a) who develops the plan, who participates in the process, and the timing of the plan; (b) the types of assessments that are conducted to support the service plan development process, including securing information about participant needs, preferences and goals, and health status; (c) how the participant is informed of the services that are available under the waiver; (d) how the plan development process ensures that the

service plan addresses participant goals, needs (including health care needs), and preferences; (e) how waiver and other services are coordinated; (f) how the plan development process provides for the assignment of responsibilities to implement and monitor the plan; and, (g) how and when the plan is updated, including when the participant's needs change. State laws, regulations, and policies cited that affect the service plan development process are available to CMS upon request through the Medicaid agency or the operating agency (if applicable):

ADSAs process that is used to develop the participant-centered service plan, includes:

(a) Who develops the plan, who participates in the process, and the timing of the plan;

The case manager develops the plan of care along with the client and their legal representative (if applicable). The client may include any other person(s) of their choosing including family and other formal and informal supports. The initial plan of care must be completed within 30 days of the assessment date. The plan of care is updated at least annually and when significant change occurs. A significant change assessment is a face-to-face interview conducted when there has been a change for better or worse in the client's cognition, ADLs, mood and behaviors, or medical condition.

(b) the types of assessments that are conducted to support the service plan development process, including securing information about participant needs, preferences and goals, and health status;

Case managers conduct assessments using the CARE automated assessment tool. CARE leads the case manager and client systematically though a series of assessments covering multiple life domains. Assessment items are based on the Minimum Data Set (MDS) and all areas include client preferences, limitations and caregiver instructions.

Assessment areas include demographics, collateral contacts, formal and informal supports, caregiver status which includes the Zerit burden scale to assess provider burden, behavioral issues, psychosocial and legal issues. Medical assessment includes diagnoses, ability to manage medications, treatments, both skilled and unskilled, mobility and toileting.

Care assesses indicators of medical risk including number of hospitalizations, skin breakdown, history of routine and preventive medical care, medication regimen and multiple diagnoses.

CARE Screens and assessment elements:
-Client demographics including: collateral Contacts, Caregiver Status, Financial eligibility, Employment status and goals.

-Medical and health status: Current Medications and Medication Management, Diagnoses, Treatments both skilled and unskilled, Indicators of risk such as recent hospitalizations, skin problems, pain, lack of preventive care (mammograms, PSA, Colonoscopy, etc.), significant change in self sufficiency, Communication skills and resources, Ability to use the phone, vision, speech, and hearing abilities, mobility and history/risk of falls.

-Psychosocial assessment: MMSE, Memory, Each current or past behavior and successful interventions, depression, Suicide risk, Sleep patterns, Relationships and Interests, Decision Making, Client goals, Alcohol, tobacco and substance abuse.

-Legal Issues - Any legal matters concerning the client including: Risk of abuse, neglect, and/or exploitation, No contact or protection orders, Less restrictive order, Guardianship, Power of Attorney, Advanced Directives, Divorce proceedings, Eviction, Involuntary commitment, Lawsuits, Parole or probation, Pending civil or criminal proceedings.

-Activities of Daily Living including: Toileting, Nutritional/Oral status, Bathing, Dressing, Personal Hygiene, Household Tasks, Transportation, Shopping, Wood Supply if wood is the sole source of heating or cooking, Housework, Assessing for environment modifications and/or assistive equipment.

(c) How the participant is informed of the services that are available under the waiver;

Case managers provide and review with all individuals interested in services the Medicaid and Long-Term Care Services for Adults brochure (DSHS 22-619X). This booklet outlines the in-home care services, resources, and options available through ADSA including options under the Medically Needy In-Home Waiver. This booklet includes several links to information about services and resources for individuals who have internet access.

(d) How the plan development process ensures that the service plan addresses participant goals, needs (including health care needs), and preferences;

CARE auto generates the results of the assessment including all identified needs (including health care, equipment, and environment needs), client goals, and preferences into a plan of care. The plan of care will show as "incomplete" until the case manager and client have completed all sections of the assessment and addressed all identified needs. A nursing referral may be recommended or required based on certain data elements or combination of data elements (critical indicators) that were selected in the assessment. Potential critical indicators include: Unstable/potentially unstable diagnosis, caregiver training required, medication regimen affecting plan of care, nutritional status affecting plan of care, immobility risks affecting plan of care, past or present skin breakdown, and risk of skin breakdown.
The plan of care is reviewed with the client to assure that their goals and preferences are included and that the plan meets their needs. Client consent is required before the plan of care is considered complete and can be implemented.

(e) How waiver and other services are coordinated;

During the assessment process, case managers obtain the client's permission to collect information and coordinate service planning with the client's primary care provider and other service systems such as mental health and/or alcohol and substance abuse. When considering how care needs are being met, the care plan takes into account services being received from allied systems. For clients who have very complex needs or who are involved in multiple systems, cross systems case staffing may be employed.

(f) How the plan development process provides for the assignment of responsibilities to implement and monitor the plan;

The case manager has primary responsibility for implementing and monitoring the care plan. The case manager reviews the plan of care with providers prior to implementation to answer any questions and ensure the care giver understands the plan of care. The client and his/her family are encouraged to contact the case manager immediately if there are problems with the plan. As part of annual plan of care monitoring, case managers are required to make at least three additional contacts following the initial/annual face-to-face visit.

Care plans are also routinely monitored by the quality assurance process and a regular schedule of supervisor reviews.

(g) How and when the plan is updated, including when the participant's needs change. State laws, regulations, and policies cited that affect the service plan development process are available to CMS upon request through the Medicaid agency or the operating agency (if applicable):

Care plans are updated annually or when significant change occurs. Significant change is defined as a reported significant change, for better or worse, in the client's cognition, mood/behavior, ADL's or medical condition. Annual updates and significant change assessments are completed face-to-face at the client's home.Interim updates are made as necessary when there are changes in providers, schedules etc.

(h) How the participant engages in and/or directs the planning process.

ADSA policy stipulates that the client is the primary source of assessment information. The client and their legal representative (if applicable), along with the case manager develop the plan of care. The client may include any other person(s) of their choosing including family and other formal and informal supports. The client has free choice of providers and employer authority for personal care services. Within the parameters of the program, client's can choose the services that will best meet their needs.

References:
- CARE, Chapter 3, Long Term Care Manual
- Case Management, Chapter 5, Long Term Care Manual
- Personal Care, Chapter 7, Long Term Care Manual
- 388-106 WAC, Long Term Care Services

Appendix D: Participant-Centered Planning and Service Delivery

D-1: Service Plan Development (5 of 8)

e. **Risk Assessment and Mitigation.** Specify how potential risks to the participant are assessed during the service plan development process and how strategies to mitigate risk are incorporated into the service plan, subject to participant needs and preferences. In addition, describe how the service plan development process addresses backup plans and the arrangements that are used for backup.

Risk assessment is incorporated directly into service planning. CARE assessments identify clients who are potentially or currently at risk. Risk assessment screens cover common areas of risk such as: mental and physical health, medication use and management, nutrition, behaviors, personal safety, and environment. CARE creates critical indicators based on certain data elements or combination of data elements identified by the case manager and client. These critical indicators require the case manager to address each element based on the level of risk and client choice. These indicators include: Unstable/potentially unstable diagnosis, Caregiver training required, Medication regimen affecting plan of care, Nutritional status affecting plan of care, Immobility risks affecting plan of care, and past or present skin breakdown.

Exception to Rule (ETR) requests may be submitted if the hours/daily rate generated by the CARE algorithm does not meet the participant's direct and ADL care needs. Managers of statewide HCS programs conduct team review of ETR's weekly. ETR approvals are based on the clinical characteristics and specific care needs of the participant.

Back up plans are discussed and planned for during the assessment process. The case manager assists with alternatives such as using a Home Care Agency or locating a back up provider in the provider Registry.

Every plan of care must include an evacuation plan. If evacuation without assistance is difficult or impossible the case manager and client discuss the risks involved and possible outcomes. The case manager discusses long term care settings that may meet the individual's needs and reduce risk. If the individual chooses to stay at home, the case manager documents the client's decision.

Appendix D: Participant-Centered Planning and Service Delivery

D-1: Service Plan Development (6 of 8)

f. **Informed Choice of Providers.** Describe how participants are assisted in obtaining information about and selecting from among qualified providers of the waiver services in the service plan.

Clients are given free choice of all qualified approved providers of each service included in the plan of care. Case managers assist clients in locating qualified providers. The case manager will work with the client to qualify a provider when the client wishes to hire and supervise a personal care provider of their choice. All providers must meet the qualifications specified in Appendix C of this waiver.

The case manager can help the client locate an IP through the State's existing IP registry. If the client has computer access, he/she may access the IP registry directly. The registry allows for access to information about available IP's in a geographic area who are interested in providing in-home personal care services.

Appendix D: Participant-Centered Planning and Service Delivery

D-1: Service Plan Development (7 of 8)

g. **Process for Making Service Plan Subject to the Approval of the Medicaid Agency.** Describe the process by which the service plan is made subject to the approval of the Medicaid agency in accordance with 42 CFR §441.301(b)(1)(i):

ADSA is an administration within DSHS, the State Medicaid Agency. ADSA determines client eligibility and requires the use of the department's electronic assessment and service planning tool. ADSA directly authorizes all initial service plans and conducts quality assurance activities on all service plans. ADSA has direct electronic access to all service plans.

A statewide random sample of service plans is reviewed by the ADSA quality assurance unit on an eighteen month cycle. The sample size is calculated to arrive at a targeted confidence level and confidence intervals.

In addition to review of electronic service plans, the ADSA Quality Assurance unit conducts on-site and home visits to assess consumer satisfaction and the accuracy and quality of service plans.

Quality assurance processes may result in corrective actions, adjustments to training curriculum, policy clarifications, forms revision, WAC revisions and targeting criteria for the next review cycle.

Appendix D: Participant-Centered Planning and Service Delivery

D-1: Service Plan Development (8 of 8)

h. Service Plan Review and Update. The service plan is subject to at least annual periodic review and update to assess the appropriateness and adequacy of the services as participant needs change. Specify the minimum schedule for the review and update of the service plan:

- ○ **Every three months or more frequently when necessary**
- ○ **Every six months or more frequently when necessary**
- ◉ **Every twelve months or more frequently when necessary**
- ○ **Other schedule**

  Specify the other schedule:

i. Maintenance of Service Plan Forms. Written copies or electronic facsimiles of service plans are maintained for a minimum period of 3 years as required by 45 CFR §74.53. Service plans are maintained by the following *(check each that applies):*

- ☑ **Medicaid agency**
- ☐ **Operating agency**
- ☐ **Case manager**
- ☑ **Other**

  Specify:

  Local offices maintain written copies of service plans for three years. Electronic copies of the CARE assessment including service plan are maintained by the Medicaid Agency.

Appendix D: Participant-Centered Planning and Service Delivery

D-2: Service Plan Implementation and Monitoring

a. Service Plan Implementation and Monitoring. Specify: (a) the entity (entities) responsible for monitoring the implementation of the service plan and participant health and welfare; (b) the monitoring and follow-up method(s) that are used; and, (c) the frequency with which monitoring is performed.

(a) The entity (entities) responsible for monitoring the implementation of the service plan and participant health and welfare;

ADSA and AAA Case Managers have primary responsibility for monitoring the implementation of plans of care and client health and welfare. The implementation and monitoring of the plans of care ensure that services are provided as outlined. Case managers adjust plans of care as needed or requested by the client. In addition, ADSA quality assurance activities provide monitoring of service plan implementation.

Providers are bound by contract to notify the case manager when there are changes in the client's condition or needs. Collateral contacts are encouraged to notify the case manager with any concerns.

(b) The monitoring and follow-up method(s) that are used; and, (c) the frequency with which monitoring is

performed.

Case managers are required to have a minimum of three annual contacts with the client in addition to the initial/annual face-to-face visit. If a significant change occurs, the case manager is required to make a face-to-face contact. When problems/barriers with services or providers are identified, the case manager works with the client to develop solutions and ensure access to waiver and non-waiver (including health) services and free choice of providers. Back-up plans are reviewed for effectiveness and revised accordingly.

Supervisors/Managers at the local level monitor a sample of each case manager's records to ensure that services are furnished as outlined in the plan of care and are meeting the needs, goals, and preferences of the client. ADSA quality assurance unit monitors at a statewide level a sample of each case manager's files. If problems are identified in individual records, supervisors/case managers are expected to remediate the problem within specified time frames. Aggregate information is used at the state level for system improvement.

Additional monitoring and oversight is provided by established Quality Improvement and Management systems described in Appendix G

b. Monitoring Safeguards. *Select one:*

- **Entities and/or individuals that have responsibility to monitor service plan implementation and participant health and welfare may not provide other direct waiver services to the participant.**
- **Entities and/or individuals that have responsibility to monitor service plan implementation and participant health and welfare may provide other direct waiver services to the participant**

  The State has established the following safeguards to ensure that monitoring is conducted in the best interests of the participant. *Specify:*

Appendix E: Participant Direction of Services

Applicability *(from Application Section 3, Components of the Waiver Request)*:

- **Yes. This waiver provides participant direction opportunities.** Complete the remainder of the Appendix.
- **No. This waiver does not provide participant direction opportunities.** Do not complete the remainder of the Appendix.

CMS urges states to afford all waiver participants the opportunity to direct their services. Participant direction of services includes the participant exercising decision-making authority over workers who provide services, a participant-managed budget or both. CMS will confer the Independence Plus designation when the waiver evidences a strong commitment to participant direction.

Indicate whether Independence Plus designation is requested *(select one):*

- **Yes. The State requests that this waiver be considered for Independence Plus designation.**
- **No. Independence Plus designation is not requested.**

Appendix E: Participant Direction of Services

E-1: Overview (1 of 13)

a. Description of Participant Direction. In no more than two pages, provide an overview of the opportunities for participant direction in the waiver, including: (a) the nature of the opportunities afforded to participants; (b) how participants may take advantage of these opportunities; (c) the entities that support individuals who direct their services and the supports that they provide; and, (d) other relevant information about the waiver's approach to participant direction.

a) The nature of the opportunities afforded to participants:

Participants who choose to receive personal care services from individual providers have employer authority and are considered the common law employer.

(b) How participants may take advantage of these opportunities:

All participants have the option of accessing agency services or becoming the employer of record for an individual provider. If the waiver recipient chooses to hire an individual provider they are considered the common law employer.

(c) The entities that support individuals who direct their services and the supports that they provide:
The Home Care Quality Authority (HCQA) is a small state agency established to improve the quality of long term In-Home services provided by In-Home providers through improved regulations, higher standards, increased accountability, and the enhanced ability of consumers to obtain services. In addition, the Authority was created to encourage stability in the In-Home provider work force. HCQA provides the following services/resources: A referral registry used to connect waiver participants to providers, assistance with hiring and employee management and training for clients on employer functions.

The Aging and Disability Services Administration (ADSA) provides: Training for Individual Providers, Background checks, Contract assistance, Financial management services, Case Management services.

Appendix E: Participant Direction of Services

E-1: Overview (2 of 13)

b. Participant Direction Opportunities. Specify the participant direction opportunities that are available in the waiver. *Select one*:

- (●) **Participant: Employer Authority.** As specified in ***Appendix E-2, Item a***, the participant (or the participant's representative) has decision-making authority over workers who provide waiver services. The participant may function as the common law employer or the co-employer of workers. Supports and protections are available for participants who exercise this authority.
- ( ) **Participant: Budget Authority.** As specified in ***Appendix E-2, Item b***, the participant (or the participant's representative) has decision-making authority over a budget for waiver services. Supports and protections are available for participants who have authority over a budget.
- ( ) **Both Authorities.** The waiver provides for both participant direction opportunities as specified in ***Appendix E-2***. Supports and protections are available for participants who exercise these authorities.

c. Availability of Participant Direction by Type of Living Arrangement. *Check each that applies*:

- [x] **Participant direction opportunities are available to participants who live in their own private residence or the home of a family member.**
- [ ] **Participant direction opportunities are available to individuals who reside in other living arrangements where services (regardless of funding source) are furnished to fewer than four persons unrelated to the proprietor.**
- [ ] **The participant direction opportunities are available to persons in the following other living arrangements**

Specify these living arrangements:

Appendix E: Participant Direction of Services

E-1: Overview (3 of 13)

d. Election of Participant Direction. Election of participant direction is subject to the following policy *(select one):*

- ○ **Waiver is designed to support only individuals who want to direct their services.**
- ◉ **The waiver is designed to afford every participant (or the participants representative) the opportunity to elect to direct waiver services. Alternate service delivery methods are available for participants who decide not to direct their services.**
- ○ **The waiver is designed to offer participants (or their representatives) the opportunity to direct some or all of their services, subject to the following criteria specified by the State. Alternate service delivery methods are available for participants who decide not to direct their services or do not meet the criteria.**

Specify the criteria

Appendix E: Participant Direction of Services

E-1: Overview (4 of 13)

e. Information Furnished to Participant. Specify: (a) the information about participant direction opportunities (e.g., the benefits of participant direction, participant responsibilities, and potential liabilities) that is provided to the participant (or the participant's representative) to inform decision-making concerning the election of participant direction; (b) the entity or entities responsible for furnishing this information; and, (c) how and when this information is provided on a timely basis.

(a) Information about participant direction opportunities

Clients have a right to select the service providers that will be meet their needs. In order for the client to make an informed choice, the case manager is responsible for describing to the client the differences in the client's role based on their choice of an individual provider or home care agency provider. If the waiver participant chooses an individual provider they are given a form entitled "Acknowledgement of my responsibilities as the employer of my individual providers".

This document provides the waiver participant with information about being an employer and resources for related skill development; information about the financial management role of DSHS; and information about the role of the Home Care Quality Authority (HCQA).

(b) The entity or entities responsible for furnishing this information:

The Case Resource Manager/Social Worker is responsible for furnishing the information to the waiver participant.

(c) How and when this information is provided on a timely basis:

Case managers provide information throughout the assessment and service plan development process. The 'Acknowledgement of My Responsibilities as an Employer of My Individual Providers' form is given to the client during service planning. Information is also available on the ADSA internet and through the HCQA.

Appendix E: Participant Direction of Services

E-1: Overview (5 of 13)

f. Participant Direction by a Representative. Specify the State's policy concerning the direction of waiver services by a representative *(select one):*

- (●) **The State does not provide for the direction of waiver services by a representative.**
- ( ) **The State provides for the direction of waiver services by representatives.**

Specify the representatives who may direct waiver services: *(check each that applies)*:

- [ ] **Waiver services may be directed by a legal representative of the participant.**
- [ ] **Waiver services may be directed by a non-legal representative freely chosen by an adult participant.**

Specify the policies that apply regarding the direction of waiver services by participant-appointed representatives, including safeguards to ensure that the representative functions in the best interest of the participant:

Appendix E: Participant Direction of Services

E-1: Overview (6 of 13)

g. Participant-Directed Services. Specify the participant direction opportunity (or opportunities) available for each waiver service that is specified as participant-directed in Appendix C-1/C-3.

Participant-Directed Waiver Service	Employer Authority	Budget Authority
Personal Care	☑	☐

Appendix E: Participant Direction of Services

E-1: Overview (7 of 13)

h. Financial Management Services. Except in certain circumstances, financial management services are mandatory and integral to participant direction. A governmental entity and/or another third-party entity must perform necessary financial transactions on behalf of the waiver participant. *Select one*:

- (●) **Yes. Financial Management Services are furnished through a third party entity.** *(Complete item E-1-i).*

Specify whether governmental and/or private entities furnish these services. *Check each that applies*:

- [x] **Governmental entities**
- [ ] **Private entities**

- ( ) **No. Financial Management Services are not furnished. Standard Medicaid payment mechanisms are used.** *Do not complete Item E-1-i.*

Appendix E: Participant Direction of Services

E-1: Overview (8 of 13)

i. Provision of Financial Management Services. Financial management services (FMS) may be furnished as a waiver service or as an administrative activity. *Select one*:

- ( ) **FMS are covered as the waiver service specified in Appendix C1/C3**

The waiver service entitled:

FMS are provided as an administrative activity.

Provide the following information

i. **Types of Entities:** Specify the types of entities that furnish FMS and the method of procuring these services:

State Medicaid Agency

ii. **Payment for FMS.** Specify how FMS entities are compensated for the administrative activities that they perform:

Per the CMS approved cost allocation plan

iii. **Scope of FMS.** Specify the scope of the supports that FMS entities provide *(check each that applies)*:

Supports furnished when the participant is the employer of direct support workers:

- **Assists participant in verifying support worker citizenship status**
- **Collects and processes timesheets of support workers**
- **Processes payroll, withholding, filing and payment of applicable federal, state and local employment-related taxes and insurance**
- **Other**

Specify:

The Medicaid Agency completes background checks and contracts with providers.

The process for collecting and processing timesheets can be either paper based or telephonic depending on the preference of the provider. The state produces a paper invoice with authorized hours. The provider must enter actual hours and sign the invoice. Accuracy is verified retrospectively via quality assurance processes.

Supports furnished when the participant exercises budget authority:

- **Maintains a separate account for each participant's participant-directed budget**
- **Tracks and reports participant funds, disbursements and the balance of participant funds**
- **Processes and pays invoices for goods and services approved in the service plan**
- **Provide participant with periodic reports of expenditures and the status of the participant-directed budget**
- **Other services and supports**

Specify:

Additional functions/activities:

- **Executes and holds Medicaid provider agreements as authorized under a written agreement with the Medicaid agency**
- **Receives and disburses funds for the payment of participant-directed services under an agreement with the Medicaid agency or operating agency**
- **Provides other entities specified by the State with periodic reports of expenditures and the status of the participant-directed budget**

☑ **Other**

Specify:

The State Medicaid Agency provides FMS including executing and holding the Medicaid provider agreements

iv. Oversight of FMS Entities. Specify the methods that are employed to: (a) monitor and assess the performance of FMS entities, including ensuring the integrity of the financial transactions that they perform; (b) the entity (or entities) responsible for this monitoring; and, (c) how frequently performance is assessed.

(a) Monitor and assess the performance of FMS entities, including ensuring the integrity of the financial transactions that they perform:

The state Medicaid agency performs the FMS functions.

Routine methods to assure accuracy of payments and client satisfaction are as follows: Supervisory review of client files; Case Resource Managers/Social Workers verify during annual reviews that services were provided as planned, the State Auditors Office and Operations Review and Consultation conduct routine audits of agency payments.The state Medicaid agency conducts client satisfaction surveys every two years. AAAs are required to conduct client satisfaction surveys every two years.

(b) The entity (or entities) responsible for this monitoring: The State Auditors Office and Operation Review and Consultation conduct routine audits of agency payments.

(c) How frequently performance is assessed: Performance is assessed by the Case Manager at least annually at the time of plan review and at significant change, the State Auditors Office performs annual audits of the state Medicaid agency, and Operations Review and Consultation (an internal DSHS office) performs periodic audits of state programs. The state Medicaid agency conducts client satisfaction surveys every two years. AAAs are required to conduct client satisfaction surveys every two years.

Appendix E: Participant Direction of Services

E-1: Overview (9 of 13)

j. Information and Assistance in Support of Participant Direction. In addition to financial management services, participant direction is facilitated when information and assistance are available to support participants in managing their services. These supports may be furnished by one or more entities, provided that there is no duplication. Specify the payment authority (or authorities) under which these supports are furnished and, where required, provide the additional information requested *(check each that applies)*:

☐ **Case Management Activity.** Information and assistance in support of participant direction are furnished as an element of Medicaid case management services.

Specify in detail the information and assistance that are furnished through case management for each participant direction opportunity under the waiver:

☐ **Waiver Service Coverage.** Information and assistance in support of participant direction are provided through the following waiver service coverage(s) specified in Appendix C-1/C-3 (check each that applies):

Participant-Directed Waiver Service	Information and Assistance Provided through this Waiver Service Coverage
Personal Care	☐
Personal Emergency Response	☐

Environmental Accessibility Adaptations	☐
Skilled Nursing	☐
Transportation	☐
Home Health Aide	☐
Adult Day Care	☐
Caregiver/Recipient Training Services	☐
Home Delivered Meals	☐
Specialized Medical Equipment and Supplies	☐
Community Transition Services	☐
In Home Nurse Delegation	☐

☑ **Administrative Activity.** Information and assistance in support of participant direction are furnished as an administrative activity.

Specify (a) the types of entities that furnish these supports; (b) how the supports are procured and compensated; (c) describe in detail the supports that are furnished for each participant direction opportunity under the waiver; (d) the methods and frequency of assessing the performance of the entities that furnish these supports; and, (e) the entity or entities responsible for assessing performance:

(a) The types of entities that furnish these supports: The State Medicaid Agency, AAAs and the Home Care Quality Authority (HCQA)

(b) How the supports are procured and compensated: Case management through the Medicaid Agency and AAAs is funded through state funds and administrative match per the approved cost allocation plan; HCQA is a state agency funded by administrative match per the cost allocation plan and through legislative appropriation of state general funds.

(c) Describe in detail the supports that are furnished for each participant direction opportunity under the waiver: During service plan development the Case Manager is responsible for informing the waiver participant of their ability to choose an individual provider or an agency provider. If the waiver participant chooses an individual provider they are informed they will become the employer of record and are given a form entitled "Acknowledgement of my responsibilities as the employer of my individual providers". This document provides the waiver participant with:
oInformation about being an employer and resources for related skill development
oInformation about the financial management role of DSHS
oInformation about the role of the Home Care Quality Authority (HCQA)

The Home Care Quality Authority (HCQA) provides:
oA referral Registry used to connect waiver participants to providers and staff to assist.
oAssistance with hiring and employee management.
oClient training on employer functions

(d) The methods and frequency of assessing the performance of the entities that furnish these supports: State Case Managers receive yearly performance evaluations per state personnel policies. Supervisory audits are required for a standard percentage of records for each case manager.

AAAs are monitered on-site every two years and recieve desk audits in the alternate year.

The ADSA Quality Assurance Unit conducts record reviews on an 18 month cycle state-wide.

The legislature conducts an audit of HCQA every three years.

e) The entity or entities responsible for assessing performance: The Department of Social and Health Services

(State Medicaid Agency) and the legislature.

Appendix E: Participant Direction of Services

E-1: Overview (10 of 13)

k. Independent Advocacy *(select one).*

- **No. Arrangements have not been made for independent advocacy.**
- **Yes. Independent advocacy is available to participants who direct their services.**

Describe the nature of this independent advocacy and how participants may access this advocacy:

Appendix E: Participant Direction of Services

E-1: Overview (11 of 13)

l. Voluntary Termination of Participant Direction. Describe how the State accommodates a participant who voluntarily terminates participant direction in order to receive services through an alternate service delivery method, including how the State assures continuity of services and participant health and welfare during the transition from participant direction:

Participants are able to switch to and from agency/individual provided personal care at any time. The Case Manager facilitates the transition and assures continuity of care from one provider to the next.

Appendix E: Participant Direction of Services

E-1: Overview (12 of 13)

m. Involuntary Termination of Participant Direction. Specify the circumstances when the State will involuntarily terminate the use of participant direction and require the participant to receive provide-managed services instead, including how continuity of services and participant health and welfare is assured during the transition.

The state does not have a mechanism for involuntary termination of participant direction. The state may terminate payment to an individual provider for cause. In this case the Case Manager assures continuity of care.

Appendix E: Participant Direction of Services

E-1: Overview (13 of 13)

n. Goals for Participant Direction. In the following table, provide the State's goals for each year that the waiver is in effect for the unduplicated number of waiver participants who are expected to elect each applicable participant direction opportunity. Annually, the State will report to CMS the number of participants who elect to direct their waiver services.

Table E-1-n

	Employer Authority Only	Budget Authority Only or Budget Authority in Combination with Employer Authority

Waiver Year	Number of Participants	Number of Participants
Year 1	100	
Year 2	100	
Year 3	100	
Year 4 (renewal only)	100	
Year 5 (renewal only)	100	

Appendix E: Participant Direction of Services

E-2: Opportunities for Participant Direction (1 of 6)

a. Participant - Employer Authority *Complete when the waiver offers the employer authority opportunity as indicated in Item E-1-b:*

i. Participant Employer Status. Specify the participant's employer status under the waiver. *Select one or both*:

☐ **Participant/Co-Employer.** The participant (or the participant's representative) functions as the co-employer (managing employer) of workers who provide waiver services. An agency is the common law employer of participant-selected/recruited staff and performs necessary payroll and human resources functions. Supports are available to assist the participant in conducting employer-related functions.

Specify the types of agencies (a.k.a., agencies with choice) that serve as co-employers of participant-selected staff:

☑ **Participant/Common Law Employer.** The participant (or the participant's representative) is the common law employer of workers who provide waiver services. An IRS-Approved Fiscal/Employer Agent functions as the participant's agent in performing payroll and other employer responsibilities that are required by federal and state law. Supports are available to assist the participant in conducting employer-related functions.

ii. Participant Decision Making Authority. The participant (or the participant's representative) has decision making authority over workers who provide waiver services. *Select one or more decision making authorities that participants exercise*:

☑ **Recruit staff**
☐ **Refer staff to agency for hiring (co-employer)**
☑ **Select staff from worker registry**
☑ **Hire staff common law employer**
☐ **Verify staff qualifications**
☐ **Obtain criminal history and/or background investigation of staff**

Specify how the costs of such investigations are compensated:

☑ **Specify additional staff qualifications based on participant needs and preferences so long as such qualifications are consistent with the qualifications specified in Appendix C-1/C-3.**
☑ **Determine staff duties consistent with the service specifications in Appendix C-1/C-3.**

- ☐ **Determine staff wages and benefits subject to State limits**
- ☑ **Schedule staff**
- ☑ **Orient and instruct staff in duties**
- ☑ **Supervise staff**
- ☑ **Evaluate staff performance**
- ☑ **Verify time worked by staff and approve time sheets**
- ☑ **Discharge staff (common law employer)**
- ☐ **Discharge staff from providing services (co-employer)**
- ☐ **Other**

Specify:

Appendix E: Participant Direction of Services

E-2: Opportunities for Participant-Direction (2 of 6)

b. Participant - Budget Authority *Complete when the waiver offers the budget authority opportunity as indicated in Item E-1-b:*

Answers provided in Appendix E-1-b indicate that you do not need to complete this section.

i. Participant Decision Making Authority. When the participant has budget authority, indicate the decision-making authority that the participant may exercise over the budget. *Select one or more*:

- ☐ **Reallocate funds among services included in the budget**
- ☐ **Determine the amount paid for services within the State's established limits**
- ☐ **Substitute service providers**
- ☐ **Schedule the provision of services**
- ☐ **Specify additional service provider qualifications consistent with the qualifications specified in Appendix C-1/C-3**
- ☐ **Specify how services are provided, consistent with the service specifications contained in Appendix C-1/C-3**
- ☐ **Identify service providers and refer for provider enrollment**
- ☐ **Authorize payment for waiver goods and services**
- ☐ **Review and approve provider invoices for services rendered**
- ☐ **Other**

Specify:

Appendix E: Participant Direction of Services

E-2: Opportunities for Participant-Direction (3 of 6)

b. Participant - Budget Authority

Answers provided in Appendix E-1-b indicate that you do not need to complete this section.

ii. **Participant-Directed Budget** Describe in detail the method(s) that are used to establish the amount of the participant-directed budget for waiver goods and services over which the participant has authority, including how the method makes use of reliable cost estimating information and is applied consistently to each participant. Information about these method(s) must be made publicly available.

Appendix E: Participant Direction of Services

E-2: Opportunities for Participant-Direction (4 of 6)

b. Participant - Budget Authority

Answers provided in Appendix E-1-b indicate that you do not need to complete this section.

iii. **Informing Participant of Budget Amount.** Describe how the State informs each participant of the amount of the participant-directed budget and the procedures by which the participant may request an adjustment in the budget amount.

Appendix E: Participant Direction of Services

E-2: Opportunities for Participant-Direction (5 of 6)

b. Participant - Budget Authority

Answers provided in Appendix E-1-b indicate that you do not need to complete this section.

iv. **Participant Exercise of Budget Flexibility.** *Select one*:

- **Modifications to the participant directed budget must be preceded by a change in the service plan.**
- **The participant has the authority to modify the services included in the participant directed budget without prior approval.**

Specify how changes in the participant-directed budget are documented, including updating the service plan. When prior review of changes is required in certain circumstances, describe the circumstances and specify the entity that reviews the proposed change:

Appendix E: Participant Direction of Services

E-2: Opportunities for Participant-Direction (6 of 6)

b. Participant - Budget Authority

Answers provided in Appendix E-1-b indicate that you do not need to complete this section.

v. **Expenditure Safeguards.** Describe the safeguards that have been established for the timely prevention of the premature depletion of the participant-directed budget or to address potential service delivery problems that may be associated with budget underutilization and the entity (or entities) responsible for implementing these safeguards:

Appendix F: Participant Rights

Appendix F-1: Opportunity to Request a Fair Hearing

The State provides an opportunity to request a Fair Hearing under 42 CFR Part 431, Subpart E to individuals: (a) who are not given the choice of home and community-based services as an alternative to the institutional care specified in Item 1-F of the request; (b) are denied the service(s) of their choice or the provider(s) of their choice; or, (c) whose services are denied, suspended, reduced or terminated. The State provides notice of action as required in 42 CFR §431.210.

Procedures for Offering Opportunity to Request a Fair Hearing. Describe how the individual (or his/her legal representative) is informed of the opportunity to request a fair hearing under 42 CFR Part 431, Subpart E. Specify the notice (s) that are used to offer individuals the opportunity to request a Fair Hearing. State laws, regulations, policies and notices referenced in the description are available to CMS upon request through the operating or Medicaid agency.

Fair hearing policies and corresponding State regulations ensure that all persons have the right to apply for Long-term Care (LTC) services administered by the department, and all applicants/clients have the right to have their financial and program eligibility determined by the department, the right to appeal any decision made by AAA or HCS staff which they perceive as adversely impacting their LTC services including, but not limited to the denial of services, reduction in the level of services, suspension of services, or termination of service. Fair Hearing Policy and Procedure is outlined in Chapter 1 of the State Long Term Care Manual. Implementation and tracking of Fair Hearings is accomplished through an automated database.

All waiver clients sign and receive a copy the 'Acknowledgement of Services' form (DSHS 14-225). This form is used to inform clients of their choices regarding waiver and institutional services and of their fair hearing rights.

The case manager informs the applicant/client verbally AND in writing when the AAA or HCS denies, suspends, reduces, or terminates services and explains the reason(s) for the action or decision in question, including the facts upon which the decision was based. The applicant/client must always be informed of the right to a fair hearing and how to make a fair hearing request. A fair hearing request form (DSHS 08-013) is included with the letter sent to the client. The client is informed that fair hearing requests may be made verbally or in writing.

The case manager documents in the Service Episode Record (SER) an applicant/client’s decision not to request a fair hearing, and includes:
The date,the topic of discussion,that the fair hearing process has been explained; and the client’s decision.

Medicaid Agency References:
DSHS form 14-225 - Acknowledgement of Services
Chapter 388-02 WAC
DSHS hearing rules
WAC 388-02 and its successors

GENERAL
388-02-0005 What is the purpose and scope of this chapter?
388-02-0010 What definitions apply to this chapter?
388-02-0015 How do the terms in the Administrative Procedure Act (APA) compare to this chapter?
388-02-0020 What does good cause mean?
ADDRESSES
388-02-0025 Where is the office of administrative hearings located?
388-02-0030 Where is the board of appeals located?
DEADLINES
388-02-0035 How are days counted when calculating deadlines for the hearing process?

FILING AND SERVING PAPERS
388-02-0040 How do parties send documents?
388-02-0045 What is service?
388-02-0050 How does a party serve someone?
388-02-0055 When must a party serve someone?
388-02-0060 When is service complete?
388-02-0065 How does a party prove service?
388-02-0070 What is filing?
388-02-0075 How does a party file documents?
RESOLUTION OF DISPUTES
388-02-0080 What are your options for resolving a dispute with DSHS?
HEARING RIGHTS AND REQUESTS
388-02-0085 Do you have a right to a hearing?
388-02-0090 Who may request a hearing?
388-02-0095 What if you have questions about requesting a hearing?
388-02-0100 How do you request a hearing?
388-02-0105 What information do you give when requesting a hearing?
388-02-0110 What happens after you request a hearing?
388-02-0115 May you withdraw your hearing request?
INTERPRETERS
388-02-0120 Do you have the right to an interpreter in the hearing process?
388-02-0125 What definitions apply to limited English proficient (LEP) parties?
388-02-0130 What requirements apply to notices for limited English speaking parties?
388-02-0135 What requirements apply to interpreters?
388-02-0140 May you waive interpreter services?
388-02-0145 What requirements apply to the use of interpreters?
388-02-0150 What requirements apply to hearing decisions involving limited English speaking parties?
REPRESENTATION DURING THE HEARING PROCESS
388-02-0155 Who represents you during the hearing process?
388-02-0160 If a DSHS employee cannot represent you, can they assist you during the hearing process?
388-02-0165 What if you would like to be represented by an attorney but you cannot afford one?
388-02-0170 Who represents DSHS during the hearing?
PREHEARING MEETING WITH A DSHS REPRESENTATIVE
388-02-0175 What is a prehearing meeting?
388-02-0180 What happens during a prehearing meeting?
388-02-0185 What happens after a prehearing meeting?
388-02-0190 What happens if you do not participate in a prehearing meeting?
PREHEARING CONFERENCE WITH AN ADMINISTRATIVE LAW JUDGE
388-02-0195 What is a prehearing conference?
388-02-0200 What happens during a prehearing conference?
388-02-0205 What happens after a prehearing conference?
388-02-0210 What happens if a party does not attend a prehearing conference?
ADMINISTRATIVE LAW JUDGES
388-02-0215 What is the authority of the ALJ?
388-02-0220 What rules and laws must an ALJ and review judge apply when making a decision?
388-02-0225 May an ALJ or review judge decide that a DSHS rule is invalid?
388-02-0230 When is the ALJ assigned to the hearing?
388-02-0235 May a party request a different judge?
388-02-0240 How does a party file a motion of prejudice?
388-02-0245 May an ALJ or review judge be disqualified?
NOTICES
388-02-0250 What happens after you request a hearing?
388-02-0255 What information must OAH include in the notice of hearing?
388-02-0260 May DSHS amend a notice?
388-02-0265 May you amend your hearing request?
388-02-0270 Must you tell DSHS and OAH when your mailing address changes?
CONTINUANCES
388-02-0275 What is a continuance?
388-02-0280 Who may request a continuance?
DISMISSALS
388-02-0285 What is an order of dismissal?

388-02-0290 If your hearing is dismissed, may you request another hearing?
388-02-0295 Where do you send a request to vacate an order of dismissal?
388-02-0300 What is the deadline for vacating an order of dismissal?
388-02-0305 How does an ALJ vacate an order of dismissal?
STAYS
388-02-0310 May a party request a stay of DSHS action?
SUBPOENAS
388-02-0315 May a party require witnesses to testify or provide documents?
388-02-0320 Who may prepare a subpoena?
388-02-0325 How is a subpoena served?
388-02-0330 May the ALJ quash a subpoena?
388-02-0335 Do you have to pay for a subpoena?
HEARING METHODS
388-02-0340 How is your hearing held?
388-02-0345 Is an ALJ present at your hearing?
388-02-0350 Is your hearing recorded?
388-02-0355 Who may attend your hearing?
388-02-0360 May a party convert how a hearing is held?
388-02-0365 How does a party convert how a hearing is held or how the witnesses or parties appear?
388-02-0370 How are documents submitted for a telephone conference?
388-02-0375 What happens at your hearing?
388-02-0380 What is a group hearing?
388-02-0385 May a party withdraw from a group hearing?
EVIDENCE
388-02-0390 What is evidence?
388-02-0395 When may the parties bring in evidence?
388-02-0400 What evidence may the parties present during the hearing?
388-02-0405 What is a stipulation?
388-02-0410 After the parties agree to a stipulation, may they change or reject it?
388-02-0415 What are proposed exhibits?
388-02-0420 Do the parties mark and number their proposed exhibits?
388-02-0425 Who decides whether to admit proposed exhibits into the record?
388-02-0430 What may a party do if they disagree with an exhibit?
388-02-0435 When should an ALJ receive proposed exhibits for a telephone hearing?
388-02-0440 What is judicial notice?
388-02-0445 How does the ALJ respond to requests to take judicial notice?
WITNESSES
388-02-0450 What is a witness?
388-02-0455 Who may be a witness?
388-02-0460 How do witnesses testify?
388-02-0465 May the parties cross-examine a witness?
388-02-0470 May witnesses refuse to answer questions?
PROOF
388-02-0475 What evidence does an ALJ consider?
388-02-0480 What does burden of proof mean?
388-02-0485 What is the standard of proof?
388-02-0490 How is a position proven at hearing?
388-02-0495 What is equitable estoppel?
RECORD CLOSURE
388-02-0500 What may an ALJ do before the record is closed?
388-02-0505 When is the record closed?
388-02-0510 What happens when the record is closed?
HEARING DECISIONS
388-02-0515 What happens after the record is closed?
388-02-0520 What information must the ALJ include in the decision?
388-02-0524 In what cases does the ALJ enter the hearing decision as an initial order?
388-02-0525 When do initial orders become final?
388-02-0527 In what cases does the ALJ enter the hearing decision as a final order?
388-02-0530 What if a party disagrees with the ALJ's decision?
CLERICAL ERRORS IN ALJ DECISIONS
388-02-0540 How are clerical errors in ALJ decisions corrected?

388-02-0545 How does a party ask for a corrected ALJ decision?
388-02-0550 How much time do the parties have to ask for a corrected ALJ decision?
388-02-0555 What happens when a party requests a corrected ALJ decision?
REQUESTS FOR BOA REVIEW OF INITIAL ORDERS FOR CASES LISTED IN WAC 388-02-0215(4)
388-02-0560 What is review?
388-02-0565 What evidence does the review judge consider in a decision?
388-02-0570 Who may request review?
388-02-0575 What must a party include in the review request?
388-02-0580 What is the deadline for requesting review of cases listed in WAC 388-02-0215(4)?
388-02-0585 Where does a party send a request to review a case listed in WAC 388-02-0215(4)?
388-02-0590 How does a party respond to the review request?
388-02-0595 What happens after the response deadline?
REVIEW JUDGES
388-02-0600 What is the authority of the review judge?
REQUESTS FOR RECONSIDERATION OF FINAL ORDERS ENTERED BY OAH AND BOA
388-02-0605 What if a party does not agree with a final order entered by OAH or BOA?
388-02-0610 What is reconsideration?
388-02-0615 What must a party include in the reconsideration request?
388-02-0620 What is the deadline for requesting reconsideration?
388-02-0625 Where does a party send a reconsideration request?
388-02-0630 How does a party respond to a reconsideration request?
388-02-0635 What happens after a party requests reconsideration?
REQUESTS FOR JUDICIAL REVIEW OF FINAL ORDERS
388-02-0640 What is judicial review?
388-02-0645 When must you ask for judicial review?
388-02-0650 How do you serve your petition for judicial review?

Long Term Care Manual Chapter 1

Appendix F: Participant-Rights

Appendix F-2: Additional Dispute Resolution Process

a. Availability of Additional Dispute Resolution Process. Indicate whether the State operates another dispute resolution process that offers participants the opportunity to appeal decisions that adversely affect their services while preserving their right to a Fair Hearing. *Select one:*

- (●) **No. This Appendix does not apply**
- ( ) **Yes. The State operates an additional dispute resolution process**

b. Description of Additional Dispute Resolution Process. Describe the additional dispute resolution process, including: (a) the State agency that operates the process; (b) the nature of the process (i.e., procedures and timeframes), including the types of disputes addressed through the process; and, (c) how the right to a Medicaid Fair Hearing is preserved when a participant elects to make use of the process: State laws, regulations, and policies referenced in the description are available to CMS upon request through the operating or Medicaid agency.

Appendix F: Participant-Rights

Appendix F-3: State Grievance/Complaint System

a. Operation of Grievance/Complaint System. *Select one:*

- ( ) **No. This Appendix does not apply**
- (●) **Yes. The State operates a grievance/complaint system that affords participants the opportunity to register**

grievances or complaints concerning the provision of services under this waiver

b. Operational Responsibility. Specify the State agency that is responsible for the operation of the grievance/complaint system:

The system is operated by the Medicaid Agency through the Aging and Disability Services Administration

c. Description of System. Describe the grievance/complaint system, including: (a) the types of grievances/complaints that participants may register; (b) the process and timelines for addressing grievances/complaints; and, (c) the mechanisms that are used to resolve grievances/complaints. State laws, regulations, and policies referenced in the description are available to CMS upon request through the Medicaid agency or the operating agency (if applicable).

References:(1) ADSA Complaint/Grievance Policy for Home and Community Services Division and the Division of Developmental Disabilities
(2)Management Bulletin H05-018 – Policy/Procedure Client Grievance Policy March 2005
(3)DSHS Administrative Policy No. 8.11

Describe the grievance/complaint system, including:
(a) the types of grievances/complaints that participants may register;
Participants may register complaints about anything the Department does or is responsible for that they perceive as effecting them negetively in any way. To protect participant rights, some types of complaints are immediately directed to other formal systems rather than being addressed through the grievance process. Complaints not handled through the grievance process include the following:

a.Complaints of abuse, neglect or financial exploitation of a vulnerable adult or child - referred to formal protective systems
b. Client disputes about services that have been Denied, Reduced, Suspended, or Terminated - client is informed of their rights and referred to the fair hearing process
c. Complaints about possible Medicaid fraud - referred to the Medicaid Fraud Control Unit

(b) the process and timelines for addressing grievances/complaints;
Complaints can be received and addressed at any level of the organization. However, ADSA always strives to address grievances/complaints at the lowest level possible. Upon receipt at any level, all DSHS employees are required to respond to in-person or telephone complaints within 1 business day. Writen complainst must receive a response within 7 business days. Complaints are referred to the case manager for action unless the complainant requests it not be. If the casemanager is unable to resolve the complaint, the person is referred to the casemanager's supervisor. The supervisor has ten working days from the date of receipt to attempt to resolve the issue. If the person feels their complaint is not resolved they are referred to the Regional Manager/AAA Director. The Manager/Director has ten working days to seek resolution.If the person continues to feel their complaint is not resolved, they are referred to the state level ADSA headquarters. ADSA has ten working days to resolve the complaint and must notify the person in writing of the outcome. All steps in this process are logged.

(c) the mechanisms that are used to resolve grievances/complaints.

Mechanisims that are used as appropriate to the type of complaint may include record review and correction of any errors; case conferences with the client; a change of providers; information and referral; additional information on program policies, statutes, administrative rules;and adjustment to the plan of care.

Appendix G: Participant Safeguards

Appendix G-1: Response to Critical Events or Incidents

a. State Critical Event or Incident Reporting Requirements. Specify the types of critical events or incidents (including alleged abuse, neglect and exploitation) that the State requires to be reported for review and follow-up action by an appropriate authority, the individuals and/or entities that are required to report such events and incidents and the timelines for reporting. State laws, regulations, and policies that are referenced are available to CMS upon request through the Medicaid agency or the operating agency (if applicable).

References:

-RCW 74.34: Abuse of Vulnerable Adults statute
-WAC 388-71-0100 through 01280: Adult Protective Services
-HCS Long-Term Care Manual, Chapter 6, policies and procedures of the Adult Protective Services Program

Required reporting of allegations involving waiver participants: What, when and to whom:

RCW 74.34.035 Reports (excerpt):
(1) When there is reasonable cause to believe that abandonment, abuse, financial exploitation, or neglect of a vulnerable adult has occurred, mandated reporters shall immediately report to the department.

(2) When there is reason to suspect that sexual assault has occurred, mandated reporters shall immediately report to the appropriate law enforcement agency and to the department.

(3) When there is reason to suspect that physical assault has occurred or there is reasonable cause to believe that an act has caused fear of imminent harm:
(a) Mandated reporters shall immediately report to the department; and
(b) Mandated reporters shall immediately report to the appropriate law enforcement agency, except as provided in subsection (4) of this section.
(4) A mandated reporter is not required to report to a law enforcement agency, unless requested by the injured vulnerable adult or his or her legal representative or family member, an incident of physical assault between vulnerable adults that causes minor bodily injury and does not require more than basic first aid, unless:
(a) The injury appears on the back, face, head, neck, chest, breasts, groin, inner thigh, buttock, genital, or anal area;
(b) There is a fracture;
(c) There is a pattern of physical assault between the same vulnerable adults or involving the same vulnerable adults; or
(d) There is an attempt to choke a vulnerable adult.

Required reporters of allegations of abuse, abandonment, neglect and financial exploitation:

RCW 74.34.020 Definitions: (8) "Mandated reporter" is an employee of the department; law enforcement officer; social worker; professional school personnel; individual provider; an employee of a facility; an operator of a facility; an employee of a social service, welfare, mental health, adult day health, adult day care, home health, home care, or hospice agency; county coroner or medical examiner; Christian Science practitioner; or health care provider subject to chapter 18.130 RCW.

b. Participant Training and Education. Describe how training and/or information is provided to participants (and/or families or legal representatives, as appropriate) concerning protections from abuse, neglect, and exploitation, including how participants (and/or families or legal representatives, as appropriate) can notify appropriate authorities or entities when the participant may have experienced abuse, neglect or exploitation.

The following resources illustrate ways that participants, family members, caregivers and/or legal representatives are provided information about protections from mistreatment and told how to report concerns or incidents of abuse, neglect, and exploitation:

•Every CARE assessment addresses potential abuse, neglect and exploitation;
•Every participant reviews and signs a form entitled “Your Rights and Responsibilities”(including the right to be free from abuse…) at the time they accept services;
•The participant financial eligibility process also includes a review of funds and information on client financial rights;
•ADSA publications (e.g., Medicaid and Options for Long-Term Care Services for Adults);
•Provider training (e.g., Caregiver Orientation, and Revised Fundamentals of Caregiving and Safety Training);
•ADSA and DSHS internet websites;
•Eldercare Locator (AoA);
•DSHS End Harm campaign and the activities associated with the annual statewide July Adult Abuse Prevention month.

c. Responsibility for Review of and Response to Critical Events or Incidents. Specify the entity (or entities) that receives reports of critical events or incidents specified in item G-1-a, the methods that are employed to evaluate such reports, and the processes and time-frames for responding to critical events or incidents, including conducting investigations.

References:

oRCW 74.34: Abuse of Vulnerable Adults statute
oWAC 388-71-0100 through 01280: Adult Protective Services
oHCS Long-Term Care Manual, Chapter 6, policies and procedures of the Adult Protective Services Program

Reports of the abuse, abandonment, neglect, financial exploitation or self-neglect of a participant are received by Adult Protective Services by phone, fax, letter, or in-person.

When indicated, APS will summon an appropriate emergency resource during intake (e.g., law enforcement when a crime against a person or property is in progress; emergency medical services when the vulnerable adult is in need of immediate medical assistance; or a mental health agency when the vulnerable adult is threatening to harm self or others or cognitive impairment is so severe that it is unsafe to be alone).

Each intake report is reviewed and preliminary information is gathered in order to determine if APS has jurisdiction; whether the allegations will be investigated by APS; and the time frame for initiation of each investigation.

Based on the facts and circumstances known at intake, reports are prioritized and assigned for investigation based on the severity and immediacy of actual or potential physical, mental or financial harm to the alleged victim, as follows:

•"High" priority when serious or life threatening harm is occurring or appears to be imminent.
-APS will conduct an unannounced private interview with the alleged victim within 24 hours of receipt of the report.
•"Medium" priority when harm that is more than minor, but does not appear to be life threatening at this time, has occurred, is on going, or may occur.
-APS will conduct an unannounced private interview with the alleged victim within 5 working days of receipt of the report.
•"Low" priority when harm that poses a minor risk at this time to health or safety, has occurred, is ongoing, or may occur.
-APS will conduct an unannounced private interview with the alleged victim within 10 working days of receipt of the report.

On a case-by-case basis, the supervisor or designee may specify a specific response time shorter than the maximum response time designated for the priority level.

d. Responsibility for Oversight of Critical Incidents and Events. Identify the State agency (or agencies) responsible for overseeing the reporting of and response to critical incidents or events that affect waiver participants, how this oversight is conducted, and how frequently.

Adult Protective Services is a state wide program within the state single Medicaid agency. The intakes, investigations and protective services performed by APS are continuously monitored at both the state and the regional levels. For example:

oRegional supervisors and program managers conduct on-going quality assurance audits of APS case records.

oThe APS program is pilot testing a new statewide QA monitoring system that will provide detailed statewide summaries of adherence to a variety of program requirements and will include a formal in-person skills evaluation conducted by a supervisor during an actual APS investigation.

oSeveral reports based on data pulled from the statewide APS data base are routinely generated and evaluated by program managers and upper management at the state office.

oThe regions have and use a report system tool that enables them to create customized reports pulled from the statewide data base to track, monitor and evaluate implementation of APS in their region.

oAPS also routinely reports some aspects of program performance to the Governor for her review (Government Management Accountability and Performance).

Appendix G: Participant Safeguards

Appendix G-2: Safeguards Concerning Restraints and Restrictive Interventions (1 of 2)

a. Use of Restraints or Seclusion. *(Select one)*:

- **The State does not permit or prohibits the use of restraints or seclusion**

  Specify the State agency (or agencies) responsible for detecting the unauthorized use of restraints or seclusion and how this oversight is conducted and its frequency:

  The Medicaid Agency through the Aging and Disabiliy Services Administration is responsible for detecting the unauthorized use of restraints or seclusion.

  Required training for all paid caregivers includes clear instructions that any use of seclusion or restraint is prohibited. Caregivers are among the people that Washington State Law (RCW 74.34) lists as mandatory reporters of suspected abuse. Mandatory training includes detailed information on types of prohibited restraint (physical, chemical, environmental), risks related to the use of restraints, and alternatives to the use of restraints.

  The Medicaid Agency detects use of restraint and seclusion through reports received in the Adult Protective Services system, through the face to face CARE assessment process conducted yearly and at significant change, through the grievance process and through quality assurance activities that may include face to face interviews of clients and review of complaints.

  Clients who choose to self direct their personal care have the authority to hire and fire at any time providing an additional protection.

- **The use of restraints or seclusion is permitted during the course of the delivery of waiver services**. Complete Items G-2-a-i and G-2-a-ii.

  i. Safeguards Concerning the Use of Restraints or Seclusion. Specify the safeguards that the State has established concerning the use of each type of restraint (i.e., personal restraints, drugs used as restraints, mechanical restraints or seclusion). State laws, regulations, and policies that are referenced are available to CMS upon request through the Medicaid agency or the operating agency (if applicable).

  ii. State Oversight Responsibility. Specify the State agency (or agencies) responsible for overseeing the use of restraints or seclusion and ensuring that State safeguards concerning their use are followed and how such oversight is conducted and its frequency:

Appendix G: Participant Safeguards

Appendix G-2: Safeguards Concerning Restraints and Restrictive Interventions (2 of 2)

b. Use of Restrictive Interventions. *(Select one)*:

- **The State does not permit or prohibits the use of restrictive interventions**

  Specify the State agency (or agencies) responsible for detecting the unauthorized use of restrictive interventions and how this oversight is conducted and its frequency:

  The Medicaid Agency through the Aging and Disabiliy Services Administration is responsible for detecting the unauthorized use of restrictive interventions.

  Required training for all paid caregivers includes clear instructions that any use of restrictive intervention is prohibited. Mandatory training includes detailed information on types restrictive interventions that are beyond the obvious use of restraint and seclusion. Training also includes multiple alternatives to restrictive intervention

and instructs the caregiver to consult with others involved in the person's care such as family and case managers.

The Medicaid Agency detects use of restrictive intervention through reports received in the Adult Protective Services system, through the face to face CARE assessment process conducted yearly and at significant change, through the grievance process and through quality assurance activities that may include face to face interviews of clients and review of complaints.

Clients who choose to self direct their personal care have the authority to hire and fire at any time.

- **The use of restrictive interventions is permitted during the course of the delivery of waiver services**

Complete Items G-2-b-i and G-2-b-ii.

i. **Safeguards Concerning the Use of Restrictive Interventions.** Specify the safeguards that the State has in effect concerning the use of interventions that restrict participant movement, participant access to other individuals, locations or activities, restrict participant rights or employ aversive methods (not including restraints or seclusion) to modify behavior. State laws, regulations, and policies referenced in the specification are available to CMS upon request through the Medicaid agency or the operating agency.

ii. **State Oversight Responsibility.** Specify the State agency (or agencies) responsible for monitoring and overseeing the use of restrictive interventions and how this oversight is conducted and its frequency:

Appendix G: Participant Safeguards

Appendix G-3: Medication Management and Administration (1 of 2)

This Appendix must be completed when waiver services are furnished to participants who are served in licensed or unlicensed living arrangements where a provider has round-the-clock responsibility for the health and welfare of residents. The Appendix does not need to be completed when waiver participants are served exclusively in their own personal residences or in the home of a family member.

a. Applicability. Select one:

- **No. This Appendix is not applicable** *(do not complete the remaining items)*
- **Yes. This Appendix applies** *(complete the remaining items)*

b. Medication Management and Follow-Up

i. **Responsibility.** Specify the entity (or entities) that have ongoing responsibility for monitoring participant medication regimens, the methods for conducting monitoring, and the frequency of monitoring.

ii. **Methods of State Oversight and Follow-Up.** Describe: (a) the method(s) that the State uses to ensure that participant medications are managed appropriately, including: (a) the identification of potentially harmful practices (e.g., the concurrent use of contraindicated medications); (b) the method(s) for following up on potentially harmful practices; and, (c) the State agency (or agencies) that is responsible for follow-up and oversight.

Appendix G: Participant Safeguards

Appendix G-3: Medication Management and Administration (2 of 2)

c. Medication Administration by Waiver Providers

Answers provided in G-3-a indicate you do not need to complete this section

i. Provider Administration of Medications. *Select one:*

- **Not applicable.** *(do not complete the remaining items)*
- **Waiver providers are responsible for the administration of medications to waiver participants who cannot self-administer and/or have responsibility to oversee participant self-administration of medications.** *(complete the remaining items)*

ii. State Policy. Summarize the State policies that apply to the administration of medications by waiver providers or waiver provider responsibilities when participants self-administer medications, including (if applicable) policies concerning medication administration by non-medical waiver provider personnel. State laws, regulations, and policies referenced in the specification are available to CMS upon request through the Medicaid agency or the operating agency (if applicable).

iii. Medication Error Reporting. *Select one of the following:*

- **Providers that are responsible for medication administration are required to both record and report medication errors to a State agency (or agencies).**
  Complete the following three items:

  (a) Specify State agency (or agencies) to which errors are reported:

  (b) Specify the types of medication errors that providers are required to *record:*

  (c) Specify the types of medication errors that providers must *report* to the State:

- **Providers responsible for medication administration are required to record medication errors but make information about medication errors available only when requested by the State.**

  Specify the types of medication errors that providers are required to record:

iv. State Oversight Responsibility. Specify the State agency (or agencies) responsible for monitoring the performance of waiver providers in the administration of medications to waiver participants and how monitoring is performed and its frequency.

Appendix H: Quality Management Strategy (1 of 2)

Under §1915(c) of the Social Security Act and 42 CFR §441.302, the approval of an HCBS waiver requires that CMS determine that the State has made satisfactory assurances concerning the protection of participant health and welfare, financial accountability and other elements of waiver operations. Renewal of an existing waiver is contingent upon review by CMS and a finding by CMS that the assurances have been met. By completing the HCBS waiver application, the State specifies how it has designed the waiver's critical processes, structures and operational features in order to meet these

assurances.

- Quality Management is a critical operational feature that an organization employs to continually determine whether it operates in accordance with the approved design of its program, meets statutory and regulatory assurances and requirements, achieves desired outcomes, and identifies opportunities for improvement.

CMS recognizes that a state's waiver Quality Management Strategy may vary depending on the nature of the waiver target population, the services offered, and the waiver's relationship to other public programs, and will extend beyond regulatory requirements. However, for the purpose of this application, the State is expected to have, at the minimum, systems in place to measure and improve its own performance in meeting six specific waiver assurances and requirements.

It may be more efficient and effective for a Quality Management Strategy to span multiple waivers and other long-term care services. CMS recognizes the value of this approach and will ask the state to identify other waiver programs and long-term care services that are addressed in the Quality Management Strategy.

Quality management is dynamic and the Quality Management Strategy may, and probably will, change over time. Modifications or updates to the Quality Management Strategy shall be submitted to CMS in conjunction with the annual report required under the provisions of 42 CFR §441.302(h) and at the time of waiver renewal.

Quality Management Strategy: Minimum Components

The Quality Management Strategy that will be in effect during the period of the waiver is included as Attachment #1 to Appendix H. The Quality Management Strategy should be no more than ten-pages in length. It may reference other documents that provide additional supporting information about specific elements of the Quality Management Strategy. Other documents that are cited must be available to CMS upon request through the Medicaid agency or the operating agency (if appropriate).

In the QMS, a state spells out:

- The evidence based *discovery* activities that will be conducted for each of the six major waiver assurances;
- The *remediation* processes followed when problems are identified in the implementation of each of the assurances;
- The *system improvement* processes followed in response to aggregated, analyzed information collected on each of the assurances;
- The correspondent *roles/responsibilities* of those conducting discovery activities, assessing, remediating and improving system functions around the assurances; and
- The process that the state will follow to continuously *assess the effectiveness of the QMS* and revise it as necessary and appropriate.

If the State's Quality Management Strategy is not fully developed at the time the waiver application is submitted, the state may provide a work plan to fully develop its Quality Management Strategy, including the specific tasks that the State plans to undertake during the period that the waiver is in effect, the major milestones associated with these tasks, and the entity (or entities) responsible for the completion of these tasks.

When the Quality Management Strategy spans more than one waiver and/or other types of long-term care services under the Medicaid State plan, specify the control numbers for the other waiver programs and identify the other long-term services that are addressed in the Quality Management Strategy.

Appendix H: Quality Management Strategy (2 of 2)

Attachment #1

The Quality Management Strategy for the waiver is:
The Quality Management Strategy for this waiver also encompasses the State Plan Medicaid Personal Care Service, the Community Options Program Entry System (COPES) Waiver (control # 0049), the New Freedom Waiver (control # 0443) and the Medically Needy Residential Waiver (MNRW) (control # 0390). The QMS is built on the HCBS Quality Framework and integrates CMS waiver assurance requirements and quality improvement/assurance activities. A full copy of the QMS is available upon request.

ADSA uses a quality assurance automated monitoring application that integrates the ADSA quality framework, inclusive of all CMS assurances and requirements, at strategic points throughout the waiver services delivery system. The QA program is a key component of the overall Quality Management strategy.

QA systematically analyzes data and information to improve training, support and waiver participant outcomes. ADSA has a distinct QA unit that conducts quality assurance activities with waiver participants, case management field offices and Area Agencies on Aging. The role and functions of QA are defined in State statute. Statute directs that QA be consumer-centered, provide continuous quality improvement and emphasize consumer satisfaction with services and outcomes (RCW 74.39A.050).

The QA application is designed to be used in conjunction with another key component of the quality management system, CARE, an automated comprehensive assessment and benefit rate-setting tool used for individuals applying for waiver services. CARE is used to determine eligibility, level of care, and performs various comprehensive functions that permit the assessor to learn about and document any/all safety issues for waiver consumers. CARE generates several distinct reports accessed by the QA Unit that managers and supervisors also use to conduct on-going QA activities to ensure compliance with CMS assurances.

Numerous reports and aggregate data generated by the QA application are available on a continuous basis for use by managers, supervisors and the QA Unit. ADSA QA policy and procedure, (Chapter 23 of the ADSA Long Term Care Manual), mandates that reports be used for discovery, remediation and to identify strengths and weaknesses, training needs, areas of deficiencies and identify corrective action plans. There is continuity and integration of report review throughout ADSA. When the QA team completes compliance reviews, preliminary results, including strengths, weaknesses and potential compliance issues/errors are sent to the Regional Administrator/AAA Director and their management team. Specific action steps including corrective action and follow-up site visits are required for QA reports. Reports generated by QA and CARE are listed at the end of this appendix.

Report Review, Roles and Responsibilities related to QMS QA:
1.Case Managers and Financial Service Specialists analyze results of individual reviews for work performance self improvement,
2.Social Service and Financial Supervisors analyze results of individual staff reviews and unit statistics to identify local areas of improvement, policy changes and training;
3.Field Managers/Regional Directors/ Area Agency on Aging (AAA) Directors/contracted entities analyze results of unit and Regional/AAA statistics identify areas of improvement, policy changes and training;
4.ADSA Program Managers analyze results of regional/AAA and statewide statistics in relation to their program to identify policy changes, areas of improvement and training,
5.ADSA/HCS Office Chiefs, HCS Deputy Director, HCS Director analyze results of Regional/AAA and statewide statistics in relation to HCS programs to identify changes in policy, areas of improvement and training,
6.ADSA Assistant Secretary reviews statewide statistics in relation to ADSA programs to identify changes in policy, areas of improvement and training,
7.ADSA is forming a statewide QA advisory committee that will include LTC providers, recipients, advocates, families, and allied systems.

These roles are applicable to all CMS assurances in addition to any additional roles listed under specific assurances.

For consumers receiving in-home waiver services, the ADSA Quality Assurance Unit utilizes a variety of data collection methodologies, (on-site, desk monitoring, home visits), to determine consumer satisfaction, program eligibility, accuracy and quality of file documents, and to determine if policy & procedures, state and federal statutes including waiver requirements are met. Waiver participants are reviewed using random sampling and appropriately sized subgroups. The subgroup sizes are calculated to arrive at a targeted confidence level and confidence intervals.

The Quality Assurance Specialists (QAS) within the QA unit perform the following duties:
1. Provide professional training/consultation to field staff.
2. Draft amendments and revisions to the Quality Assurance Program including recommendations for policies and procedures. These recommendations are based upon quality assurance activity findings, feedback and input received from consumers and staff.
3. Monitor social service files.
4. Monitor provider records to confirm that Individual Provider files are in compliance, which means the providers:
a)Passed criminal background checks. The QAS will review the criminal background check to establish that the provider has not been convicted of a crime that would prohibit the individual provider from caring for a vulnerable adult.
b)Received required training.

c)Have completed the required specialty training to provide care to persons with dementia, mental illness or developmental disabilities.
d)Have a properly executed Medicaid provider agreement.
5. Conduct QI focus activities based on trends and patterns that may indicate regional or statewide issues.

State Unit on Aging (SUA)
The SUA is responsible for oversight of Area Agency on Aging (AAA) operations including the following areas:
• Implementation and compliance with contract requirements, state and federal laws and regulations, policies and procedures.
• Approval and oversight of program budgets, billing for services provided, and Area Plan development and implementation.
• Review of corrective action plans submitted by AAAs to correct deficiencies in AAA operations and monitoring implementation of corrective actions.
• Review of monitoring reports submitted by AAAs for subcontractors to determine compliance with Inter-local agreement and related laws and regulations.

Home & Community Programs (HCP)
The HCP unit is responsible for development of policy and procedures related to HCS quality assurance/improvement activities, oversight of assessment, service planning and delivery models, monitoring compliance to Home & Community programs, including HCBS. HCP monitors field compliance through the following methods:

• On-going review of Social Service Payment System (SSPS) reports for irregularities in waiver or other payment authorizations.
• On-going review of CARE generated reports for program compliance and eligibility criteria.
• Investigation of complaints or inquiries from the field staff, Medicaid fraud Control Unit, Payment Integrity unit, ADSA budget unit, constituents, legislative staff and other DSHS entities.
• Review of various reports regarding the daily operation of the home & community programs.
• Program review and eligibility consultation to supervisors and field staff.
• Policy briefings and program updates for QA staff.
• Social worker and Case Manager training.
• Consideration of requests for additional personal care hours to meet exceptional need.

Several information systems are utilized to evaluate performance. These are:
• Medicaid Management Information System (MMIS) – contains Medicaid-paid claims under the state plan for hospitalizations including community psychiatric hospitalizations, nursing home use, emergency room visits, treatment provided by physicians and other medical providers, and prescriptions. MMIS data provides information on type of service received, costs, diagnoses, procedures, and type of medication.
• Client Services Database (CSDB) –an integrated cross-program database which contains information on service use and costs for all services provided by DSHS.
• Social Service Payment System (SSPS) - service use and costs for home- and community-based long-term care. (Continuous live data)
• CARE – assessments of the consumer's functional abilities (Activities of Daily Living – ADL), mood and behavior issues and cognitive status, medical diagnoses, and level of needed home and community-based long-term care services. Demographic data is available through this system.
• CARE management reports synthesis data tracked in association with the CMS approved Quality Strategy for Washington State.
• Participant Satisfaction Surveys

The New Freedom monitoring plan includes three supplemental activities:
• An annual survey is provided to every participant and family/legal representative to give them the opportunity to anonymously provide information on their perceptions and whether waiver requirements were met.
• New Freedom annually does an audit of PCSP's to identify whether required information is recorded, planned personal outcomes are consistent with consumer preferences and identified needs, signatures are affixed and payments are made according to the plan.
• New Freedom annually does a face-to-face sample survey of clients to assess satisfaction with waiver services and attainment of preferred outcomes.

Before expanding the New Freedom waiver to additional geographic areas ADSA will contract with a professional organization for an evaluation of the effects of the cash and counseling program on participant satisfaction, the scope and range of services available, the degree to which participants have been able to remain at home, and overall health. If significant differences are found for clients who participate in New Freedom compared to those who do not, then the

evaluation will examine the possible reasons. For example, we would explore the possible effects of New Freedom on client satisfaction and sense of control, which new services likely contributed to differences in ability to remain in-home, and will compare utilization of other Medicaid funded health services by New Freedom participants with those outside the program. Recommendations from the evaluation will be used to guide evolution and replication of the project after the start-up grant has ended.

Assurance: Level of Care (LOC) Determination
• The CARE assessment as specified in the waiver is the only assessment tool used to determine LOC. Case managers complete a LOC determination on all applicants for whom there is reasonable indication that services may be needed in the future. The following information is monitored to assure the timeliness of LOC determinations.
• Home and Community Services Intake is completed within two working day of receiving the request/referral for services – referrals are entered within one working day for clients discharging from the hospital.
• For applicants in the community, a face-to-face home visit is scheduled within five days of the request of services unless the applicant requests a different timeframe. For applicants coming home in the hospital, a face-to-face contact is made within 2 working days of receipt of referral.
• The case is assigned to a social worker (the primary case manager) within one working day of the Intake date.
• The assessment process must be completed and services authorized (if eligible) within 30 days of the date of assignment.
• The participant is re evaluated at minimum, annually and in response to significant change.
• LOC is reevaluated annually and at significant change.
• The QMS follows the Quality framework as a foundation for LOC determination monitoring. ADSA monitors LOC decisions in several ways. An algorithm in CARE runs when the assessment is complete to determine LOC. This information is reviewed by the case manager. Each year, social service supervisors/managers monitor four records per worker to ensure the LOC is accurate. For new staff, a minimum of 50% of LOCs are reviewed during the first six months of employment. Errors in assessment that can lead to inaccurate LOC determinations are corrected. ADSA QA unit monitor LOC using a statistically valid sample of records statewide. The QA unit monitors records on an 18 month review cycle.
• CARE, QA, and payment reports are reviewed and corrective action taken on an on-going basis (minimum of every 30 days) by HCS supervisors and field managers. Case managers are required to take action within specified time frames to address all inappropriate LOC determinations identified during supervisory and the QA unit monitoring. CARE Management Reports include data elements such as: intake date, first assigned date, primary Case Manager, date assessment created, date moved from pending to current (make payment), setting and transfer dates.
• Quality Assurance Proficiency and Follow-up Reports (Proficiency Report for Follow-Up Review outlines LOC decisions and corrective actions taken) include documentation of monitoring prompt assessment and eligibility determination within required timeframes, for accuracy, and corrective action. QA roll up reports are reviewed at all levels of the system. Case managers receive individualized proficiency reports, supervisors receive unit reports, RA/AAA Directors receive regional reports, and the ADSA HQ review aggregate data.

Assurance: Plan of Care
Plan of Care assurances are met through QA/Management monitoring to ensure compliance to policy & procedure, state and federal rules and regulations applicable to individual plan development, implementation, evaluation and re-assessment. The state monitors service plan development in accordance with its policies and procedures and takes appropriate action when it identifies inadequacies in service plan development. Service plans must address all participants' assessed needs (including health and safety risk factors) and personal goals, either by the provision of waiver services or through other means. Service plans are updated/revised at least annually or when warranted by changes in waiver participant needs.

• The QMS follows the Quality framework as a foundation for plan of care monitoring. ADSA monitors the plan of care in several ways. An algorithm in CARE runs when the assessment is complete to create the plan of care based on the data input by the case manager and client. CARE also tracks identified needs, including needs identified by the client, and whether providers (formal or informal) are assigned for each identified need. Each year, social service supervisors/manager monitors four records per worker to ensure the services, goals; preferences of the client are included in the plan of care and delivered as outlined. For new staff, a minimum of 50% of plans are reviewed during the first six months of employment. Errors in assessment that can lead to an incomplete plan of care are corrected. ADSA QA unit monitor plans of care using a statistically valid sample of records statewide. The QA unit monitors records on an 18 month review cycle.
• QA reports are reviewed and corrective action taken on an on-going basis (minimum of every 30 days) by HCS supervisors and field managers. Case managers are required to take action within specified time frames to address all problems identified in plans of care identified during supervisory and the QA unit monitoring.

All participants assessed needs – whether or not ADSA pays for them, are documented within CARE. A back up plan and evacuation plans are required in minimum standards. Case management is required for all waiver clients.

CARE allows the assessor to document safety issues for waiver clients such as: PERS-Personal emergency response system, evacuation in an emergency, minimum case management contacts, case management, environmental modifications, client training, skin observation protocol, critical indicators from nursing referral screen, assistance obtaining durable medical equipment, cognitive deficits, person(s) responsible for supervising caregivers, screen to document client falls, Drug/Alcohol assessments, depression screening, caregiver burnout, suicide risk, and other high-risk indicators.

QA monitoring assures that all services are delivered in accordance with the service plan, including type, scope, amount, duration, and frequency as specified in the plan of care.

The Quality Assurance Application and Care Reports, (QA monitoring data is current at the time monitoring occurred and CARE Management reports are in real time), capture the following:
• Needs identified in the LOC are adequately addressed in the participants' Plan of Care
• Plan of Care development is consumer directed and plans are completed in required time frame
• Participants receive all of the services identified in the plan of care (at minimum all services needed to assure health and welfare must be provided)
• Participants are provided the freedom to choose waiver services, institutional care, and service providers.
• Participants' choices are not limited and choice of providers is adequate to meet participant needs.
• Plans are reviewed and revised in response to participant direction or change in needs

Assurance: Qualified Providers
The assurance is met through QA/Management monitoring to ensure compliance to policy & procedure, state and federal rules and regulations applicable. ADSA QMS mandates the use of a statistically valid sampling of waiver participants to monitor the following:

Waiver participants that choose to self direct their personal care, hire, train and supervise qualified providers and are free to terminate the provider's employment and select new qualified providers. Individual and agency providers must complete Fundamentals of Care Giving Orientation within 14 days of beginning employment. Revised Fundamentals of Care giving must be completed within 120 days of employment (or 180 days for parent providers). Note: An IP may take the Modified Fundamentals of Care giving Self-Study course in lieu of the full Fundamentals course, if the IP documents successful completion of training as an RN, LPN, nursing assistant certified, PT, OT, or a Medicare certified home care aide. Continuing education of 10 hours must be completed each calendar year following the fundamentals training. Required training is outlined in WAC 388-71-05805 through WAC 388-71-05830, for an IP who will be performing a nurse delegated task. The contract is terminated if the IP does not complete the required training within the time limits listed above.

In addition to QA functions, each HCS/AAA office monitors all the individual providers for 4 randomly selected waiver participants per worker per year. Provider contract and training compliance is also monitored through the DSHS/central contracts database.

A home visit is conducted within 30 days of initial transfer to in-home case management to ensure plan is in place and being implemented, provider is adhering to requirements, and no further changes are needed.

Face-to-face monitoring and verification occurs at the annual review and/or if there a significant change. A minimum number of other contacts is specified to verify that the plan is being appropriately implemented and to review a sampling of timesheets.

Provider records are monitored to confirm that:
- Individual Provider files are compliant, which means the providers:
- Passed the WATCH and criminal background checks. The case manager will review the criminal background check to establish the provider has not been convicted of a disqualifying crime
- Properly executed provider agreement.
- Received required training.
- Providers subject to licensing/certification meet provider-specific requirements. The state re-verifies licensing or certification at the time of contract renewal and per individual licensing or certification schedule.

ADSA QMS policy specifies response times for errors including those that meet the immediate response criteria. These

include SSPS payment errors, indications of abuse, neglect, exploitation, and client safety risks; client rights violations, or poor quality of care with no indication that a referral, investigation, and/or action occurred to address the problem or issues relating to provider contracting/training that needs to be addressed immediately.

Assurance of Health and Welfare
ADSA has strong systems in place to address this assurance and to protect vulnerable adults in home and community settings from critical incidents and other life-endangering situations. The Quality Management Strategy for ensuring compliance with the Health and Welfare Assurance includes prevention training; community education and participation; continuous access to reporting, data collection, analysis, and policy review; monitoring provider actions taken when substantiation of abuse, neglect, abandonment or exploitation are found; monitoring, evaluation and actions taken by ADSA when required; investigation by law enforcement, adult protective services, residential care services and children's protective services for allegations of abuse, neglect, abandonment or exploitation.

Adult protective services reports can be accessed in a variety of ways. Standard reports are created by the Forecasting and Data Analysis unit are made available to all of ADSA, from the ADSA website as management reports Self-serve, customized, dynamic reports are available on demand through the APS automated system as created by APS Program staff and ADSA management. These reports are available based on a three level hierarchy of access: an individual worker may access reports about his/her own cases; a supervisor/program manager may access reports about his/her own region, units and workers; upper management may access reports about all individual workers, units, regions, and statewide. These reports are used for on-going evaluation to ensure that appropriate actions are taken, that analysis of abuse, neglect and exploitation trends occurs and, to facilitate day-to-day workload management.

Roles and responsibilities related to Adult Protective Services
- APS investigators analyze results of individual reviews for work performance self improvement
- APS Supervisors analyze results of individual investigators to identify local areas of improvement, policy changes and training
- Field Managers/RA analyze results of Regional statistics to identify areas of improvement, policy changes and training
- ADSA APS Program Managers analyze results of Regional and statewide statistics in relation to their program to identify policy changes, areas of improvement and training
- HCS Office Chiefs, HCS Deputy Director, HCS Director analyze results of Regional statistics in relation to HCS programs to identify changes in policy, areas of improvement and training
- ADSA Assistant Secretary reviews statewide statistics in relation to ADSA programs to identify changes in policy, areas of improvement and training
- QA Oversight Committee comprised of Field Supervisors, Managers and Directors to analyze unit statistics and identify local areas of improvement, policy changes and training needs

CARE allows the assessor to document any/all safety issues for waiver clients such as: PERS-Personal emergency response system, support needs for evacuation in an emergency, minimum case management contacts, environmental modifications , client training ,skin observation protocol ,critical indicators on nursing referral screen, assistance obtaining durable medical equipment or other assistive technology, transportation needs, cognitive performance and/or memory deficits, identification of person responsible for supervising caregivers, screen to document client falls, drug/alcohol assessments and depression screening, screening for caregiver burnout, suicide risk and environmental safety needs. CARE reports are referenced in the last section of this appendix. AAA Nursing Services respond to referrals by HCS/AAA case managers based on critical indicators identified in CARE.

Assurance: Administrative Authority

The waiver is operated by Aging and Disability Services Administration (ADSA), a separate administration within the Department of Social and Health Services (DSHS). The Medicaid agency exercises administrative discretion/oversight in the administration and supervision of the waiver by issuing all policies, rules and regulations related to the waiver. DSHS contracts with AAAs to perform certain waiver functions. Copies of these contracts are on file at the Medicaid agency. On-site contract monitoring of AAAs is performed every two years and more frequently at the discretion of the State. Performance is measured as per the terms of the contract, the waiver and identified delegated functions.

Assurance: Financial Accountability

State financial oversight exists to assure that claims are coded and paid in accordance with the reimbursement methodology specified in the approved waiver. ADSA is meeting this assurance through established QA/QI strategy that embeds monitoring of financial accountability and integrity. Monitoring is performed by ADSA HQ managers responsible for ensuring compliance with financial management policy and procedures. Quality assurance monitoring

related to financial integrity occurs at local, regional and statewide level using a variety of financial data and reports and includes analyzing aggregate data to discover statewide and/or regional trends. Financial irregularities or errors/adjustments made by the state and/or providers are identified, addressed, and corrected.

Financial records are maintained by the state, regional managing entities, and providers, as specified. CARE payments from SSPS are entered through CARE interface and a history of payment is maintained. Errors are corrected when identified within the initial monitoring review. Within the specified timeframe the QA specialist reviews the change to ensure correction has been made. If not, the issue is addressed with the AAA Director and they must indicate in their corrective action plan how this correction will occur to meet all state and federal requirements.

The QA Unit develops Initial, 30- Day, and Follow-up proficiency QA monitoring reports and approves corrective action plans. Social Services Supervisors are responsible for reviewing 4 records per case manager per year is in addition to all records being transferred between offices. Supervisors/local managers have the ability to perform targeted or additional reviews if concerns arise. Two Payment Review Program (PRP) workgroups meet on a monthly basis to review payment data and review algorithms run to identify errors in service authorization and ensure duplicate payments are not occurring. Continuous automated data systems that track waiver status and provider payments are utilized. Payment Review Program (PRP) reports which result in overpayment letters being sent are reported to office of financial management.

In addition to embedded QA activities that monitor financial functions, HCS also audits yearly a random sample of waiver client plans of care for financial integrity. The state SSPS system which is used to pay providers is also continuously monitored for promptness and accuracy utilizing live data.

An ADSA Headquarters committee reviews all SSPS data when an exceptional rate is requested to ensure compliance. AAA monitors agency providers and other waiver provider contracts. Supervisory review of payment authorization occurs twice a month using SSPS 154 & 159 authorization sheets.

HQ Program Managers review payment data for their programs, address as appropriate, and follow-up to ensure payment corrections are made. WA maintains documentation showing results of its financial monitoring process for verifying maintenance of appropriate financial records as specified in approved waiver. SSPS Cola and other SSPS reports for participation and payment data are utilized.

Roles and Responsibilities related to Financial Accountability:
• Monitoring reports are reviewed by individuals who decide what, if any, improvements are needed.
• Case managers and financial service specialists – analyze results of individual reviews for self improvement
• Social Service and Financial Supervisors analyze results of individual staff reviews and unit statistics to identify local areas of improvement, policy changes and training
• Field Managers/RA/AAA Directors analyze results of unit and Regional/AAA statistics to identify areas of improvement, policy changes and training
• ADSA Program Managers analyze results of Regional/AAA and statewide statistics in relation to their program to identify policy changes, areas of improvement and training
• HCS Office Chiefs, HCS Deputy Director, HCS Director analyze results of Regional/AAA and statewide statistics in relation to HCS programs to identify changes in policy, areas of improvement and training
• ADSA Assistant Secretary reviews statewide statistics in relation to ADSA programs to identify changes in policy, areas of improvement and training
• QA Oversight Committee reviews statewide statistics in relation to QI to identify changes in policy, areas of improvement and training

Quality Management Reports

The following types of information from reports are utilized and disseminated to other agencies, participants, families, interested parties and the public as applicable. Reports are tools to measure performance, quality of services and to ensure each assurance is met, determine corrective action and follow-up, and to evaluate the QA strategy for any adjustments to policy/procedure, during the pilot phase the New Freedom Program Manager will coordinate generation of specific reports specific to New Freedom participants. Additionally, specific quality measures are being developed in consultation with the Cash and Counseling Grant National Program Office and will be implemented and utilized at the onset of enrollment.

Quality Assurance monitoring application Reports – These reports are accessed directly from the QA monitoring application or by a specific query of the database. Reports are used to measure performance and for system planning and improvement.

Client Reviews Requiring Action Report/Initial/30-Day/Follow-up Review Report -

These reports include all errors that require correction. Issues include errors that have not been corrected, only partially corrected, or correction is unable to be verified by the supervisor or QA staff. QA staff and supervisors/field manager are able to generate this report.

Initial - The initial report is distributed at the exit conference at the completion of the compliance review and is attached to the preliminary monitoring report. It reports all files in which corrections are required.

30-Day - If there continues to be outstanding issues after the 30-day review is complete, a 30-day report is generated and attached to the preliminary monitoring report that is created by QA staff in MS Word and distributed to the RA/AAA Director. The RA/AAA director must address these areas of deficiencies in their corrective action plan.

Follow-Up - Any issues still outstanding or not addressed in the corrective action plan are documented in the follow-up report and attached to the final report to the RA/AAA Director. Issues showing up in this report could result in corrective action.

Statewide aggregate reports are forwarded to the Training Unit after the 18 month review to contribute to the analysis of case manager training needs.

Proficiency Reports

a) Case Manager Report – This report includes proficiency percentage for each question for all the reviews completed for this case manager during the review period. This will help the case manager and their supervisor identify areas that need focus or training. The report can be accessed at anytime by case managers and local management to view status of the review. A final report can be accessed once the review cycle for the local area is complete.

b) Supervisory Unit Report – This report includes proficiency percentage for each question for all the reviews completed for an identified supervisory unit during the review period. The supervisor, Region/AAA management or QA staff can generate this report at any time in the review to get a status of the review. A final report can be accessed once the review cycle for the local area is complete. It is expected that trends will be identified based on analysis of this report and training developed to address those trends.

c) Regional/AAA report – This report includes proficiency percentage for each question for all the reviews completed for an identified region/Planning Service Areas (PSA) during the review period. Regional/AAA management or QA staff can generate this report at any time in the review process to get a status of the review. A final report can be accessed once the review cycle for the local area is complete. It is expected that trends will be identified based on analysis of this report and training developed to address those trends.

d) Statewide Reports (external – accessed through a data base query, not a prepared report within the QA application) – These reports are used to identify trends and develop training to address these trends, look at policy, and determine if changes are needed, identify best practices, etc. These reports are run and distributed for analysis after the 18 month review cycle.

e) Statewide Area Reports (external) –These reports are used to identify trends and develop training to address these trends, look at policy, and determine if changes are needed, identify best practices, etc. in a regional area. Reports include data for all the AAA and HCS offices within a regional geographical area.

f) Final Statewide Region/PSA QA Comparison Report (external) – This report includes the initial, 30 day and follow-up proficiency finding for each question for each PSA/Region. It also includes highest and lowest proficiency for each question throughout the state and compares this to the statewide proficiency amount. The system has a table that stores the highest and lowest proficiencies between the regions and PSAs.

Deficiency Reports
This report shows errors relating to payment or eligibility. Errors are first identified as initial findings, and then separated into deficiency, cost savings, cost avoidance, and “deficiency” categories depending on the action taken by the case manager. QA staff generates this report and distribute it to ADSA management and the ADSA Secretary.

a) File Reviews with Deficiencies
This report displays the associated dollar values found to be in error for completed reviews related to a specific

client. The dollar values are separated into their related category per review - Findings, Cost Savings, Cost Avoidance and Deficiency. Results are displayed for each review cycle completed and ordered by review cycle start date, client, and location. These are post algorithm values. This report can only be taken from completed QAS compliance reviews.

b) Questions with deficiencies
This report displays all dollar values associated to each question that has findings for completed reviews. The dollar values are separated into their related category per review - Findings, Cost Savings, Cost Avoidance and Deficiency. Results are ordered and labeled identically to the application section and question order. The dollar values are pre algorithm values. This report can only be taken from completed QAS compliance reviews.

c) Nurse Delegation Proficiencies
This report is identical to the Proficiency report except it only contains nurse delegation questions and relevant care plan question.

CARE Reports are ad hoc reports that can be accessed by anyone at ADSA at any time. These reports are used at various levels to analyze performance, time frames, client trends and characteristics, and for system planning and performance improvement.

a) Assessment Totals - This report provides the number of assessments done by a worker and the different assessment types.

b) CARE Classification Groups - This report provides information on the client's classification, planned setting, and rate/hours. This report includes: Reporting Unit, Client name, DOB, SSN, Aces ID, assessment type, assessment status, creation date, planned county, planned facility, daily rate, classification, In home Hours, Primary worker. This report can be filtered by reporting unit, setting or status.

c) Clinical scores within CARE - This report lists the various clinical scores (e.g. MMSE) for clients in different settings. This report includes: MMSE, CPS, Depression, ADL and Setting (Planned), and # of clients. Report can be filtered by client, range for each score or setting.

d) Depression - This report lists clients with a high depression score and whether or not they are receiving mental health services. This report includes: Depression score of (X or more), plus Treatment type of Mental Health Therapy/Program, Received and can be filtered with received (y/n) or needs, (y/n).

e) Inactive Cases - This report includes information on cases that have been entered in CARE but were inactivated. This report includes: Inactive cases (client name, last assessment date, date inactive, last primary case manager), and reasons for inactive.

f) Intake Report - This report provides intake totals by workers and the outcome of the intakes (e.g. inactivation). This report includes: Who added client, client first name/last name, SSN OR DOB, Intake date, status (e.g. inactive), assessment moved to history (y/n), reason for inactivation, assigned date, primary case manager. Report can be filtered by worker and date.

g) Nursing Referrals - This report documents the number and reasons for referrals due to Critical Indicators. This report includes: Total # of indicators, Total by assessment, Refer Yes, Refer no, not answered. (Optional: How many with cognitive impairment) and reason for referral.

h) Relative Providers - This report indicates the number of clients who have paid relative providers including: Contact role: Paid caregiver, Relation to client: All relative types, and/or SSPS authorization for this contact. Living arrangement e.g. lives with provider.

i) Resource Directory - This report is an unduplicated list of all of the resources listed in the resources in CARE, which can be filtered by county or program type.

j) Response Date - This report provides information on the dates within the CARE tool, including but not limited to the intake date, the date the case was assigned to a primary case manager, the assessment date, and that the assessment was completed. It can be filtered to determine whether response times have been met. Filter elements include: Date Range. Date range between Intake Date and Date Assigned; Between Date Assigned and Assessment Date; Between Assessment Date and Completion Date; Between Completion Date and Transfer Date; and Between Transfer Date and New Assigned Date.

k) Service Delivery Overview - This report lists the number of clients in certain settings, classifications, and/or programs (e.g. specific waiver-COPES, New Freedom). This report includes: % of clients by region, reporting unit, by classification, by setting, by program, and # of clients

l) Status & Authorizations - This report indicates if there are authorizations for current assessments and conversely whether an authorization has been completed for pending assessments. This report includes: Current status, no authorizations (exclude DDD) OR pending status, authorizations, assessment dates. Pending/History unduplicated, display client names, and authorization #s.

m) Total SSPS Payments To - This report includes: Total payment to a provider, provider #, provider name. Filters include: Yearly, Quarterly, and Date Range.

Additional Miscellaneous Report utilized:

MMIS track the medical service payment (not residential payment)
SSPS maintains payments
ADSA HCA Rates – establish and track payment methodology – maintain history
SPS Caseload Authorization Reports
ACES financial database
SSPS recollection reports
Regional management/payment reports
Financial records are monitored using Audit 99 located within the BARCODE application
Audit 99 reports

ADSA's QMS is updated at a minimum every two years and evaluated in advance of the submission of waiver renewal applications. Evaluation/updates include assessing/modifying roles and responsibilities of key entities, and data sources. Entities involved in the formal evaluation of the QMS include: ADSA staff and administration, DSHS quality management committee, advocacy groups and stakeholders. Adjustments are made between scheduled evaluations to refine data, address immediate problems.

Appendix I: Financial Accountability

I-1: Financial Integrity and Accountability

Financial Integrity. Describe the methods that are employed to ensure the integrity of payments that have been made for waiver services, including: (a) requirements concerning the independent audit of provider agencies; (b) the financial audit program that the state conducts to ensure the integrity of provider billings for Medicaid payment of waiver services, including the methods, scope and frequency of audits; and, (c) the agency (or agencies) responsible for conducting the financial audit program. State laws, regulations, and policies referenced in the description are available to CMS upon request through the Medicaid agency or the operating agency (if applicable).

(a) requirements concerning the independent audit of provider agencies;

Home Care Agencies are required to have an independent financial audit without findings covering the two year period prior to contracting. The audit must be conducted by a licensed CPA or a recognized financial firm.
Federal rules are followed for agencies that have non-profit status per the Single Audit Act and OMB CIRCULAR A-133. A single or program specific audit is required for the AAA and other subcontractors who expend more than $300,000 in federal assistance in a year.
If the subcontractor is a for-profit organization, it may be a subrecipient, but it will not fall under the OMB CIRCULAR A-133 requirements for a federal single or program-specific audit. In this unique case, the for-profit is monitored annually as follows:
1. By performing a desk review of the vendor's annual audit,
2. By on-site monitoring and completion of the monitoring worksheet. AAAs are required to use the following risk factors to help determine if on-site monitoring should be done.

a. frequency of outside audits,
b. prior audit findings,
c. type of Contract,

d. dollar amount of contract,
e. internal control structure of subcontractor,
f. abnormal frequency of personnel turnover,
g. length of time as a subcontractor,
h. history of marginal performance,
i. has not conformed to conditions of previous contracts.
3. Review of subcontractor's relevant cost information when contract is renewed.
The State Auditor's Office conducts the periodic independent audit of the waiver program as required by the single audit act.

(b) the financial audit program that the state conducts to ensure the integrity of provider billings for Medicaid payment of waiver services, including the methods, scope and frequency of audits;

AAAs are responsible for monitoring Home Care Agency service contractors with whom they have executed contracts. Full on-site monitoring occurs every two years. A new subcontractor must receive a full monitoring for each of the first two years they are under contract. Abbreviated monitoring occurs in each year when full on-site monitoring does not occur. Desk monitoring occurs semi-annually. Review tools and policies are available through ADSA.
In addition to administrative review, client record and plan of care review, full on-site monitoring includes a fiscal review:
-Fiscal Review: Comparison of a sample of contractor billings/SSPS reports to contractor maintained documentation of work performed. A review of individual employee time records is part of this responsibility. The minimum sample size is 5% of current authorizations. The monitoring activity verifies that work billed for was performed, that the contractor is maintaining documentation of work performed and, that employees are paid for work performed.
An abbreviated review consists of a review of complaints and review of any items where compliance was not met during the full review. The abbreviated monitoring must be expanded to full when a subcontractor exhibits significant problems that are not corrected as required by corrective action.
Desk monitoring consists of a review of program and financial reports to compare level of service provided to the level of service authorized. AAA verification of a sample of time keeping records is required for home care agencies that exceed a ratio of provided versus authorized hours of 92% or above for the quarter reviewed. AAAs must require a written response from home care agencies that have a quarterly ratio of provided versus authorized hours that are equal to or less than 75%. If the reason for the underserved hours is primarily due to an agency's inability to appropriately respond to referrals or provide adequate staffing levels, a corrective action must be submitted by the agency.
DSHS Payment Review Program:
DSHS launched the Payment Review Program in 1999 to employ new technology to assist with the regular DSHS review of Medicaid billings for accuracy. The focus of the Payment Review Program is to identify and prevent billing and payment errors. Originally, PRP only looked at claims through the MMIS. Social Service Payment System (SSPS) billings were added to PRP in 2002.
PRP employs algorithms to detect patterns and occurrences that may indicate problem billings. DSHS has an extensive internal algorithm development and review process. To keep providers informed about finalized algorithms, the Payment Review Program has posted the algorithm descriptions on the DSHS Internet site
Teams of DSHS clinical, program and policy experts rigorously review all data analysis results from PRP reports to ensure accuracy.
Adult Day Care providers are reviewed at least annually per WAC 388-71-0724. Review includes administrative procedures and a required audited financial statement.
Monitoring for other waiver service contractors is conducted at a minimum every two years. AAAs may conduct either a full or abbreviated monitoring based on a usage/risk threshold. Triggers for a full monitoring are within a two year period: five or more authorizations or, one complaint concerning quality of care or client safety or, $5000 or more in payments or any other reason the AAA thinks a contractor needs to be monitored.
Full monitoring of other waiver service contractors includes a comparison of contractor billings to contractor-maintained documentation of work performed. Verification that the work was performed should also be obtained from the client if possible. The minimum sample size for short term or one time services such as environmental modifications, specialized medical equipment is 5% of the total clients the contractor served in the previous two years. The minimum sample size for services that are generally ongoing such as skilled nursing or PERS is 5% of current authorizations. Monitoring includes review of individual files where they exist for services such as skilled nursing, client training, adult day care, home delivered meals and home health aide services.

(c) the agency (or agencies) responsible for conducting the financial audit program. State laws, regulations, and policies referenced in the description are available to CMS upon request through the Medicaid agency or the operating agency (if applicable).

The Medicaid Agency is responsible for conducting the financial review program of AAAs. AAAs are responsible for

conducting financial review activities of subcontracted providers. The State Auditor's Office conducts the periodic independent audit of the waiver program as required by the single audit act.

Appendix I: Financial Accountability

I-2: Rates, Billing and Claims (1 of 3)

a. Rate Determination Methods. In two pages or less, describe the methods that are employed to establish provider payment rates for waiver services and the entity or entities that are responsible for rate determination. Indicate any opportunity for public comment in the process. If different methods are employed for various types of services, the description may group services for which the same method is employed. State laws, regulations, and policies referenced in the description are available upon request to CMS through the Medicaid agency or the operating agency (if applicable).

Personal Care rate determinations are the responsibility of DSHS/ADSA and based on appropriations of the Washington State Legislature. Rates are negotiated between the union representing home care workers and the Governor's office. Legislative approval and appropriation is required following agreement between the parties.

ADSA uses the CARE tool, an automated system to collect demographic data, assess functional needs and abilities, health, and medical information, determine eligibility for services, develop a care plan, and authorize services for clients receiving or requesting long-term care services.

The CARE program evaluates information about the client based on major predicators of direct care need: clinical complexity, cognitive impairment, behavioral support needs and activities and incidental activities of daily living. ADSA, through CARE, employs a client classification methodology consisting of fourteen care groups. CARE uses algorithms to place clients in a classification group based on the assessment and assigns base hours.

The base hours are adjusted to account for informal support, paid by individual(s) or group(s) other than ADSA and support provided in shared living circumstances. CARE determines the adjustment by placing a numeric value on the amount of assistance available to meet the client's needs and reduces the base hours assigned to the classification group using assigned values for each specific ADL and IADL.

The rate determination process is established in the Washington Administrative Code (WAC) that contains the rules and regulation used to determine eligibility and payment rates. ADSA followed the Administrative Procedure Ac t (APA) RCW 34.05, inclusive of established mechanisms for public comment and input on the rates process, when adopting the new regulation contained in chapter 388-72A WAC, Comprehensive Assessment and Reporting Evaluation Tool.

For waiver services other than personal care, AAAs negotiate rates within ranges published by ADSA for each service. Payment cannot exceed 1)the prevailing charges in the locality for comparable services under comparable circumstances, or 2) the rates charged by the AAA for comparable services funded by other sources. The AAA must have written procedures for determining rates that are reasonable and consistent with market rates. Acceptable methods for determining reasonable rates include periodic market surveys, cost analysis and price comparison.

Reference: AAA Policies and Procedures manual, Chapter 6

b. Flow of Billings. Describe the flow of billings for waiver services, specifying whether provider billings flow directly from providers to the State's claims payment system or whether billings are routed through other intermediary entities. If billings flow through other intermediary entities, specify the entities:

Washington utilizes two systems to process claims pertaining to the services provided to waiver recipients. State plan services are processed through the Medicaid Management Information System (MMIS) and waiver services are processed through the Social Service Payment System (SSPS).

The SSPS maintains data on waiver recipients including recipient name, birth date, social security number and case number. The recipient data is associated with the provider name, provider payment identification number, waiver service begin and end dates, unit rate, authorized service charge code, amount paid, date paid, etc.

Aging and Disability Services Administration (ADSA) social workers, community nurse consultants and Area Agency on Aging direct service and contracted case managers authorize waiver service payments for

applicant/recipients meeting financial and service eligibility factors using a DSHS 14-154, Service Authorization form. Information on the form is used to update the SSPS computer database. A copy of the completed form is retained in the recipient's case record and the service provider receives a notice of payment authorization from SSPS. The computer generates a Change of Service Authorization form (DSHS 14-159) after the first authorization is processed. ADSA and the Area Agency on Aging direct service and contracted case manager staff use this Change of Service form to add, change, or terminate services.

The Service Invoice is the basis for payment of authorized waiver services, which have been provided. Each service is shown on an invoice one time for each month it was authorized as that month ends. Even if a service has not been billed or paid for, it will not be shown on an invoice a second time unless ADSA or Area Agency on Aging direct service or contracted case manager staff re-authorize payment. The provider signs the invoice and returns it to the department. Payments are made directly to the service provider. Historical records of all payments are maintained.

Appendix I: Financial Accountability

I-2: Rates, Billing and Claims (2 of 3)

c. Certifying Public Expenditures *(select one)*:

- ○ **No. Public agencies do not certify expenditures for waiver services.**
- ◉ **Yes. Public agencies directly expend funds for part or all of the cost of waiver services and certify their public expenditures (CPE) in lieu of billing that amount to Medicaid**

***Select at least one*:**

☐ **Certified Public Expenditures (CPE) of State Public Agencies.**

Specify: (a) the public agency or agencies that certify public expenditures for waiver services; (b) how it is assured that the CPE is based on the total computable costs for waiver services; and, (c) how the State verifies that the certified public expenditures are eligible for Federal financial participation in accordance with 42 CFR §433.51(b).*(Indicate source of revenue for CPEs in Item I-4-a.)*

☑ **Certified Public Expenditures (CPE) of Non-State Public Agencies.**

Specify: (a) the non-State public agencies that incur certified public expenditures for waiver services; (b) how it is assured that the CPE is based on total computable costs for waiver services; and, (c) how the State verifies that the certified public expenditures are eligible for Federal financial participation in accordance with 42 CFR §433.51(b). *(Indicate source of revenue for CPEs in Item I-4-b.)*

(a) the non-State public agencies that incur certified public expenditures for waiver services;
County and municipal governments

(b) how it is assured that the CPE is based on total computable costs for waiver services;

CPEs are only for administrative activities. No CPEs are based on expenditures for waiver services. The administrative rate is standardized and CPEs cannot exceed the standard rate.

(c) how the State verifies that the certified public expenditures are eligible for Federal financial participation in accordance with 42 CFR §433.51(b).

The state requires certification per 42 CFR 433.51(b by the public agency that funds represent expenditures eligible for FFP.(Accounting Policy Management Board Policy #50.02 issued March 4, 2005)

Appendix I: Financial Accountability

I-2: Rates, Billing and Claims (3 of 3)

d. Billing Validation Process. Describe the process for validating provider billings to produce the claim for federal financial participation, including the mechanism(s) to assure that all claims for payment are made only: (a) when the individual was eligible for Medicaid waiver payment on the date of service; (b) when the service was included in the participant's approved service plan; and, (c) the services were provided:

The process for validating provider billings is as follows:

(a)The individual was eligible for Medicaid waiver payment on the date of service;
Aging and Disability Services Administration social workers, community nurse consultants and Area Agency on Aging direct service and contracted case manager will authorize waiver program services (as listed on the individual service plan) effective on the date all the following program factors constituting Medicaid eligibility for waiver services are satisfied:

(1)Categorical relatedness and financial eligibility are approved.
(2)The assessed applicant/recipient is eligible for nursing facility level care and is, or likely to be, institutionalized.
(3)The individual service plan is developed and approved by the Aging and Adult Services Administration social worker, community nurse consultant or the Area Agency on Aging direct service or contracted case manager.
(4)The recipient has approved the service plan.
(5)The provider is qualified for payment.
(6)The provider contract procedures are completed.

(b) The service was included in the participant's approved service plan;
The waiver services in the approved plans are not authorized until steps in the description of the mechanism for assuring payments are made only for eligible service recipients are completed. Claims for payments can be made only after Aging and Disability Services Administration staff or Area Agency on Aging direct service or contracted case managers have authorized the payment on the Social Service Payment System (SSPS) database. The only services authorized are those services listed in the client's plan of care.

(c) Verification that the services were provided:

1. Verification is obtained during face to face annual and significant change reviews with the recipient/legal representative.
2. Verification is obtained via quality management record reviews which may include face to face contact.
3.Verification may be obtained through the ADSA client grievance process - The policy and procedure for this process was updated and disseminated in 2005 (MB H05-018 – Policy/Procedure)

If billing problems are identified via the client, the QA process or the grievance process ADSA corrects the payment and adjusts the claim for FFP accordingly.

e. Billing and Claims Record Maintenance Requirement. Records documenting the audit trail of adjudicated claims (including supporting documentation) are maintained by the Medicaid agency, the operating agency (if applicable), and providers of waiver services for a minimum period of 3 years as required in 45 CFR §74.53.

Appendix I: Financial Accountability

I-3: Payment (1 of 7)

a. Method of payments -- MMIS (*select one*):

- ○ **Payments for all waiver services are made through an approved Medicaid Management Information System (MMIS).**
- ○ **Payments for some, but not all, waiver services are made through an approved MMIS.**

Specify: (a) the waiver services that are not paid through an approved MMIS; (b) the process for making such payments and the entity that processes payments; (c) and how an audit trail is maintained for all state and federal funds expended outside the MMIS; and, (d) the basis for the draw of federal funds and claiming of these expenditures on the CMS-64:

- **Payments for waiver services are not made through an approved MMIS.**

Specify: (a) the process by which payments are made and the entity that processes payments; (b) how and through which system(s) the payments are processed; (c) how an audit trail is maintained for all state and federal funds expended outside the MMIS; and, (d) the basis for the draw of federal funds and claiming of these expenditures on the CMS-64:

Washington uses two systems to process claims pertaining to the services provided to waiver recipients. State plan services are processed through the Medicaid Management Information System (MMIS) and waiver services are processed through the Social Service Payment System (SSPS).

The SSPS maintains data on waiver recipients including recipient name, birth date, social security number and case number. The recipient data is associated with the provider name, provider payment identification number, waiver service begin and end dates, unit rate, authorized service charge code, amount paid, date paid, etc.

Aging and Disability Services Administration (ADSA) social workers, community nurse consultants and Area Agency on Aging direct service and contracted case managers authorize waiver service payments for applicant/recipients meeting financial and service eligibility factors using a DSHS 14-154, Service Authorization form. Information on the form is used to update the SSPS computer database. A copy of the completed form is retained in the recipient's case record and the service provider receives a notice of payment authorization from SSPS. The computer generates a Change of Service Authorization form (DSHS 14-159) after the first authorization is processed. ADSA and the Area Agency on Aging direct service and contracted case manager staff use this Change of Service form to add, change, or terminate services.

The Service Invoice is the basis for payment of authorized waiver services, which have been provided. Each service is shown on an invoice one time for each month it was authorized as that month ends. Even if a service has not been billed or paid for, it will not be shown on an invoice a second time unless ADSA or Area Agency on Aging direct service or contracted case manager staff re-authorize payment. The provider signs the invoice and returns it to the department. Payments are made directly to the service provider. Historical records of all payments are maintained.

- **Payments for waiver services are made by a managed care entity or entities. The managed care entity is paid a monthly capitated payment per eligible enrollee through an approved MMIS.**

Describe how payments are made to the managed care entity or entities:

Appendix I: Financial Accountability

I-3: Payment (2 of 7)

b. Direct payment. In addition to providing that the Medicaid agency makes payments directly to providers of waiver services, payments for waiver services are made utilizing one or more of the following arrangements (*select at least one*):

- [x] **The Medicaid agency pays providers through the same fiscal agent used for the rest of the Medicaid program.**
- [ ] **The Medicaid agency pays providers of some or all waiver services through the use of a limited fiscal agent.**

Specify the limited fiscal agent, the waiver services for which the limited fiscal agent makes payment, the functions that the limited fiscal agent performs in paying waiver claims, and the methods by which the Medicaid agency oversees the operations of the limited fiscal agent:

☐ **Providers are paid by a managed care entity or entities for services that are included in the State's contract with the entity.**

Specify how providers are paid for the services (if any) not included in the State's contract with managed care entities.

Appendix I: Financial Accountability

I-3: Payment (3 of 7)

c. Supplemental or Enhanced Payments. Section 1902(a)(30) requires that payments for services be consistent with efficiency, economy, and quality of care. Section 1903(a)(1) provides for Federal financial participation to States for expenditures for services under an approved State plan/waiver. Specify whether supplemental or enhanced payments are made. *Select one:*

◉ **No. The State does not make supplemental or enhanced payments for waiver services.**

○ **Yes. The State makes supplemental or enhanced payments for waiver services.**

Describe:(a) the nature of the supplemental or enhanced payments that are made and the waiver services for which these payments are made and (b) the types of providers to which such payments are made. Upon request, the State will furnish CMS with detailed information about the total amount of supplemental or enhanced payments to each provider type in the waiver.

Appendix I: Financial Accountability

I-3: Payment (4 of 7)

d. Payments to Public Providers. *Specify whether public providers receive payment for the provision of waiver services.*

◉ **No. Public providers do not receive payment for waiver services.** Do not complete Item I-3-e.

○ **Yes. Public providers receive payment for waiver services.** Complete Item I-3-e.

Specify the types of public providers that receive payment for waiver services and the services that the public providers furnish: *Complete item I-3-e.*

Appendix I: Financial Accountability

I-3: Payment (5 of 7)

e. Amount of Payment to Public Providers.

Specify whether any public provider receives payments (including regular and any supplemental payments) that in the aggregate exceed its reasonable costs of providing waiver services and, if so, how the State recoups the excess and returns the Federal share of the excess to CMS on the quarterly expenditure report. *Select one:*

Answers provided in Appendix I-3-d indicate that you do not need to complete this section.

- **The amount paid to public providers is the same as the amount paid to private providers of the same service.**
- **The amount paid to public providers differs from the amount paid to private providers of the same service. No public provider receives payments that in the aggregate exceed its reasonable costs of providing waiver services.**
- **The amount paid to public providers differs from the amount paid to private providers of the same service. When a public provider receives payments (including regular and any supplemental payments) that in the aggregate exceed the cost of waiver services, the State recoups the excess and returns the federal share of the excess to CMS on the quarterly expenditure report.**

Describe the recoupment process:

Appendix I: Financial Accountability

I-3: Payment (6 of 7)

f. Provider Retention of Payments. Section 1903(a)(1) provides that Federal matching funds are only available for expenditures made by states for services under the approved waiver. *Select one:*

- **Providers receive and retain 100 percent of the amount claimed to CMS for waiver services.**
- **Providers do not receive and retain 100 percent of the amount claimed to CMS for waiver services.**

Provide a full description of the billing, claims, or payment processes that result in less than 100% reimbursement of providers. Include: (a) the methodology for reduced or returned payments; (b) a complete listing of types of providers, the amount or percentage of payments that are reduced or returned; and, (c) the disposition and use of the funds retained or returned to the State (i.e., general fund, medical services account, etc.):

- **Providers are paid by a managed care entity (or entities) that is paid a monthly capitated payment.**

Specify whether the monthly capitated payment to managed care entities is reduced or returned in part to the State.

Appendix I: Financial Accountability

I-3: Payment (7 of 7)

g. Additional Payment Arrangements

i. Voluntary Reassignment of Payments to a Governmental Agency. *Select one:*

- **No. The State does not provide that providers may voluntarily reassign their right to direct payments to a governmental agency.**
- **Yes. Providers may voluntarily reassign their right to direct payments to a governmental agency as provided in 42 CFR §447.10(e).**

Specify the governmental agency (or agencies) to which reassignment may be made.

ii. Organized Health Care Delivery System. *Select one:*

- **No. The State does not employ Organized Health Care Delivery System (OHCDS) arrangements under the provisions of 42 CFR §447.10.**
- **Yes. The waiver provides for the use of Organized Health Care Delivery System arrangements under the provisions of 42 CFR §447.10.**

Specify the following: (a) the entities that are designated as an OHCDS and how these entities qualify for designation as an OHCDS; (b) the procedures for direct provider enrollment when a provider does not voluntarily agree to contract with a designated OHCDS; (c) the method(s) for assuring that participants have free choice of qualified providers when an OHCDS arrangement is employed, including the selection of providers not affiliated with the OHCDS; (d) the method(s) for assuring that providers that furnish services under contract with an OHCDS meet applicable provider qualifications under the waiver; (e) how it is assured that OHCDS contracts with providers meet applicable requirements; and, (f) how financial accountability is assured when an OHCDS arrangement is used:

iii. Contracts with MCOs, PIHPs or PAHPs. *Select one:*

- **The State does not contract with MCOs, PIHPs or PAHPs for the provision of waiver services.**
- **The State contracts with a Managed Care Organization(s) (MCOs) and/or prepaid inpatient health plan(s) (PIHP) or prepaid ambulatory health plan(s) (PAHP) under the provisions of §1915(a)(1) of the Act for the delivery of waiver and other services. Participants may voluntarily elect to receive waiver and other services through such MCOs or prepaid health plans. Contracts with these health plans are on file at the State Medicaid agency.**

Describe: (a) the MCOs and/or health plans that furnish services under the provisions of §1915(a)(1); (b) the geographic areas served by these plans; (c) the waiver and other services furnished by these plans; and, (d) how payments are made to the health plans.

- **This waiver is a part of a concurrent §1915(b)/§1915(c) waiver. Participants are required to obtain waiver and other services through a MCO and/or prepaid inpatient health plan (PIHP) or a prepaid ambulatory health plan (PAHP). The §1915(b) waiver specifies the types of health plans that are used and how payments to these plans are made.**

Appendix I: Financial Accountability

I-4: Non-Federal Matching Funds (1 of 3)

a. State Level Source(s) of the Non-Federal Share of Computable Waiver Costs. Specify the State source or sources

of the non-federal share of computable waiver costs. *Select at least one*:

- [x] **Appropriation of State Tax Revenues to the State Medicaid agency**
- [ ] **Appropriation of State Tax Revenues to a State Agency other than the Medicaid Agency.**

If the source of the non-federal share is appropriations to another state agency (or agencies), specify: (a) the entity or agency receiving appropriated funds and (b) the mechanism that is used to transfer the funds to the Medicaid Agency or Fiscal Agent, such as an Intergovernmental Transfer (IGT), including any matching arrangement, and/or, indicate if the funds are directly expended by public agencies as CPEs, as indicated in Item I-2-c:

- [ ] **Other State Level Source(s) of Funds.**

Specify: (a) the source and nature of funds; (b) the entity or agency that receives the funds; and, (c) the mechanism that is used to transfer the funds to the Medicaid Agency or Fiscal Agent, such as an Intergovernmental Transfer (IGT), including any matching arrangement, and/or, indicate if funds are directly expended by public agencies as CPEs, as indicated in Item I-2-c:

Appendix I: Financial Accountability

I-4: Non-Federal Matching Funds (2 of 3)

b. Local or Other Source(s) of the Non-Federal Share of Computable Waiver Costs. Specify the source or sources of the non-federal share of computable waiver costs that are not from state sources. *Select One*:

- ( ) **Not Applicable**. There are no non-State level sources of funds for the non-federal share.
- (•) **Applicable**

Check each that applies:

- [ ] **Appropriation of Local Revenues.**

Specify: (a) the local entity or entities that have the authority to levy taxes or other revenues; (b) the source (s) of revenue; and, (c) the mechanism that is used to transfer the funds to the Medicaid Agency or Fiscal Agent, such as an Intergovernmental Transfer (IGT), including any matching arrangement (indicate any intervening entities in the transfer process), and/or, indicate if funds are directly expended by public agencies as CPEs, as specified in Item I-2- c:

- [x] **Other non-State Level Source(s) of Funds.**

Specify: (a) the source of funds; (b) the entity or agency receiving funds; and, (c) the mechanism that is used to transfer the funds to the State Medicaid Agency or Fiscal Agent, such as an Intergovernmental Transfer (IGT), including any matching arrangement, and /or, indicate if funds are directly expended by public agencies as CPEs, as specified in Item I-2- c:

(a) the local entity or entities that have the authority to levy taxes or other revenues;
County and Municipal Governments

(b) the source(s) of revenue; and,
county and municipal general fund

(c) the mechanism that is used to transfer the funds to the Medicaid Agency or Fiscal Agent, such as an Intergovernmental Transfer (IGT), including any matching arrangement (indicate any intervening entities in the transfer process), and/or, indicate if funds are directly expended by public agencies as CPEs, as specified in Item I-2- c:

Funds are directly expended as CPEs

Appendix I: Financial Accountability

I-4: Non-Federal Matching Funds (3 of 3)

c. Information Concerning Certain Sources of Funds. Indicate whether any of the funds listed in Items I-4-a or I-4-b that make up the non-federal share of computable waiver costs come from the following sources: (a) provider taxes or fees; (b) provider donations; and/or, (c) federal funds (other than FFP). *Select one*:

- (●) **None of the specified sources of funds contribute to the non-federal share of computable waiver costs**
- ( ) **The following source(s) are used**

Check each that applies:

- [ ] **Provider taxes or fees**
- [ ] **Provider donations**
- [ ] **Federal funds (other than FFP)**

For each source of funds indicated above, describe the source of the funds in detail:

Appendix I: Financial Accountability

I-5: Exclusion of Medicaid Payment for Room and Board

a. Services Furnished in Residential Settings. *Select one:*

- (●) **No services under this waiver are furnished in residential settings other than the private residence of the individual.**
- ( ) **As specified in Appendix C, the State furnishes waiver services in residential settings other than the personal home of the individual.**

b. Method for Excluding the Cost of Room and Board Furnished in Residential Settings. The following describes the methodology that the State uses to exclude Medicaid payment for room and board in residential settings:
Do not complete this item.

Appendix I: Financial Accountability

I-6: Payment for Rent and Food Expenses of an Unrelated Live-In Caregiver

Reimbursement for the Rent and Food Expenses of an Unrelated Live-In Personal Caregiver. *Select one:*

- (●) **No. The State does not reimburse for the rent and food expenses of an unrelated live-in personal caregiver who resides in the same household as the participant.**

Yes. Per 42 CFR §441.310(a)(2)(ii), the State will claim FFP for the additional costs of rent and food that can be reasonably attributed to an unrelated live-in personal caregiver who resides in the same household as the waiver participant. The State describes its coverage of live-in caregiver in Appendix C-3 and the costs attributable to rent and food for the live-in caregiver are reflected separately in the computation of factor D (cost of waiver services) in Appendix J. FFP for rent and food for a live-in caregiver will not be claimed when the participant lives in the caregiver's home or in a residence that is owned or leased by the provider of Medicaid services.

The following is an explanation of: (a) the method used to apportion the additional costs of rent and food attributable to the unrelated live-in personal caregiver that are incurred by the individual served on the waiver and (b) the method used to reimburse these costs:

Appendix I: Financial Accountability

I-7: Participant Co-Payments for Waiver Services and Other Cost Sharing (1 of 5)

a. Co-Payment Requirements. Specify whether the State imposes a co-payment or similar charge upon waiver participants for waiver services. These charges are calculated per service and have the effect of reducing the total computable claim for federal financial participation. *Select one:*

No. The State does not impose a co-payment or similar charge upon participants for waiver services.

Yes. The State imposes a co-payment or similar charge upon participants for one or more waiver services.

i. Co-Pay Arrangement.

Specify the types of co-pay arrangements that are imposed on waiver participants (*check each that applies*):

Charges Associated with the Provision of Waiver Services *(if any are checked, complete Items I-7-a-ii through I-7-a-iv):*

- **Nominal deductible**
- **Coinsurance**
- **Co-Payment**
- **Other charge**

Specify:

Appendix I: Financial Accountability

I-7: Participant Co-Payments for Waiver Services and Other Cost Sharing (2 of 5)

a. Co-Payment Requirements.

ii. Participants Subject to Co-pay Charges for Waiver Services.

Answers provided in Appendix I-7-a indicate that you do not need to complete this section.

Appendix I: Financial Accountability

I-7: Participant Co-Payments for Waiver Services and Other Cost Sharing (3 of 5)

a. Co-Payment Requirements.

iii. Amount of Co-Pay Charges for Waiver Services.

Answers provided in Appendix I-7-a indicate that you do not need to complete this section.

Appendix I: Financial Accountability

I-7: Participant Co-Payments for Waiver Services and Other Cost Sharing (4 of 5)

a. Co-Payment Requirements.

iv. Cumulative Maximum Charges.

Answers provided in Appendix I-7-a indicate that you do not need to complete this section.

Appendix I: Financial Accountability

I-7: Participant Co-Payments for Waiver Services and Other Cost Sharing (5 of 5)

b. Other State Requirement for Cost Sharing. Specify whether the State imposes a premium, enrollment fee or similar cost sharing on waiver participants. *Select one*:

- (●) **No. The State does not impose a premium, enrollment fee, or similar cost-sharing arrangement on waiver participants.**
- ( ) **Yes. The State imposes a premium, enrollment fee or similar cost-sharing arrangement.**

Describe in detail the cost sharing arrangement, including: (a) the type of cost sharing (e.g., premium, enrollment fee); (b) the amount of charge and how the amount of the charge is related to total gross family income; (c) the groups of participants subject to cost-sharing and the groups who are excluded; and, (d) the mechanisms for the collection of cost-sharing and reporting the amount collected on the CMS 64:

Appendix J: Cost Neutrality Demonstration

J-1: Composite Overview and Demonstration of Cost-Neutrality Formula

Composite Overview. Complete the fields in Cols. 3, 5 and 6 in the following table for each waiver year. The fields in Cols. 4, 7 and 8 are auto-calculated based on entries in Cols 3, 5, and 6. The fields in Col. 2 are auto-calculated using the Factor D data from the J-2d Estimate of Factor D tables. Col. 2 fields will be populated ONLY when the Estimate of

Factor D tables in J-2d have been completed.

Level(s) of Care: Nursing Facility

Col. 1	Col. 2	Col. 3	Col. 4	Col. 5	Col. 6	Col. 7	Col. 8
Year	Factor D	Factor D'	Total: D+D'	Factor G	Factor G'	Total: G+G'	Difference (Col 7 less Column4)
1	10213.24	11058.00	21271.24	22010.00	6106.00	28116.00	6844.76
2	10519.88	12164.00	22683.88	23111.00	6717.00	29828.00	7144.12
3	10836.10	13381.00	24217.10	24266.00	7388.00	31654.00	7436.90
4	11162.89	14719.00	25881.89	25479.00	8127.00	33606.00	7724.11
5	11496.57	16190.00	27686.57	26753.00	8940.00	35693.00	8006.43

Appendix J: Cost Neutrality Demonstration

J-2: Derivation of Estimates (1 of 9)

a. Number Of Unduplicated Participants Served. Enter the total number of unduplicated participants from Item B-3-a who will be served each year that the waiver is in operation. When the waiver serves individuals under more than one level of care, specify the number of unduplicated participants for each level of care:

Table: J-2-a: Unduplicated Participants

Waiver Year	Total Number Unduplicated Number of Participants (from Item B-3-a)	Distribution of Unduplicated Participants by Level of Care (if applicable)
		Level of Care:
		Nursing Facility
Year 1	200	200
Year 2	200	200
Year 3	200	200
Year 4 (renewal only)	200	200
Year 5 (renewal only)	200	200

Appendix J: Cost Neutrality Demonstration

J-2: Derivation of Estimates (2 of 9)

b. Average Length of Stay. Describe the basis of the estimate of the average length of stay on the waiver by participants in item J-2-a.

The estimated Average Length of Stay is based on the Average Length of Stay from the initial 372 report for the waiver year from April 1, 2005 - March 31, 2006 for waiver 0049.91.R4.02 (COPES waiver).

The COPES waiver serves a similar population, and is a better basis for estimation of the ALS for this waiver due to it's longer history and larger # of individuals served. The very limited history and # of individuals served under the Medically Needy waiver makes the actual experience for this waiver a poor basis for calculating ALS estimates.

Appendix J: Cost Neutrality Demonstration

J-2: Derivation of Estimates (3 of 9)

c. Derivation of Estimates for Each Factor. Provide a narrative description for the derivation of the estimates of the following factors.

i. Factor D Derivation. The estimates of Factor D for each waiver year are located in Item J-2-d. The basis for these estimates is as follows:

The estimates for year 3 of the waiver amendment completed in April 2005 serve as the basis for the Factor D estimates in this waiver renewal.

372 data was not used because the very limited history and # of individuals served under the Medically Needy waiver makes the actual experience for this waiver a poor basis for calculating estimates.

These estimates are increased by 3% per year based on the actual average increase over the past 3 years.

ii. Factor D' Derivation. The estimates of Factor D' for each waiver year are included in Item J-1. The basis of these estimates is as follows:

The estimates for year 3 of the waiver amendment completed in April 2005 serve as the basis for the Factor D' estimates in this waiver renewal.

372 data was not used because the very limited history and # of individuals served under the Medically Needy waiver makes the actual experience for this waiver a poor basis for calculating estimates.

These estimates are increased by 10% per year based on the actual average increase over the past 3 years.

iii. Factor G Derivation. The estimates of Factor G for each waiver year are included in Item J-1. The basis of these estimates is as follows:

The estimates for year 3 of the waiver amendment completed in April 2005 serve as the basis for the Factor G estimates in this waiver renewal.

372 data was not used because the very limited history and # of individuals served under the Medically Needy waiver makes the actual experience for this waiver a poor basis for calculating estimates.

These estimates are increased by 5% per year based on the actual average increase over the past 3 years.

iv. Factor G' Derivation. The estimates of Factor G' for each waiver year are included in Item J-1. The basis of these estimates is as follows:

The estimates for year 3 of the waiver amendment completed in April 2005 serve as the basis for the Factor G' estimates in this waiver renewal.

372 data was not used because the very limited history and # of individuals served under the Medically Needy waiver makes the actual experience for this waiver a poor basis for calculating estimates.

These estimates are increased by 10% per year based on the actual average increase over the past 3 years.

Appendix J: Cost Neutrality Demonstration

J-2: Derivation of Estimates (4 of 9)

Component management for waiver services. If the service(s) below includes two or more discrete services that are reimbursed separately, or is a bundled service, each component of the service must be listed. Select "*manage components*" to add these components.

Waiver Services
Personal Care
Personal Emergency Response
Environmental Accessibility Adaptations

Skilled Nursing
Transportation
Home Health Aide
Adult Day Care
Caregiver/Recipient Training Services
Home Delivered Meals
Specialized Medical Equipment and Supplies
Community Transition Services
In Home Nurse Delegation

Appendix J: Cost Neutrality Demonstration

J-2: Derivation of Estimates (5 of 9)

d. Estimate of Factor D.

i. Non-Concurrent Waiver. Complete the following table for each waiver year. Enter data into the Unit, # Users, Avg. Units Per User, and Avg. Cost/Unit fields for all the Waiver Service/Component items. Select Save and Calculate to automatically calculate and populate the Component Costs and Total Costs fields. All fields in this table must be completed in order to populate the Factor D fields in the J-1 Composite Overview table.

Waiver Year: Year 1

Waiver Service/ Component	Unit	# Users	Avg. Units Per User	Avg. Cost/ Unit	Component Cost	Total Cost
Personal Care Total:						**1610824.00**
Personal Care	Day	200	271.00	29.72	**1610824.00**	
Personal Emergency Response Total:						**30066.40**
Personal Emergency Response	Day	100	254.80	1.18	**30066.40**	
Environmental Accessibility Adaptations Total:						**71604.91**
Environmental Accessibility Adaptations	Job	67	2.60	411.05	**71604.91**	
Skilled Nursing Total:						**51332.82**
Skilled Nursing	Visit	33	135.50	11.48	**51332.82**	
Transportation Total:						**1973.79**
Transportation	Trip	7	216.90	1.30	**1973.79**	
Home Health Aide Total:						**144781.10**
Home Health Aide	Visit	33	183.80	23.87	**144781.10**	
Adult Day Care Total:						**13339.85**
Adult Day Care	Day	7	192.30	9.91	**13339.85**	
Caregiver/Recipient Training Services Total:						**2862.80**
Caregiver/Recipient Training Services	Hour	7	103.80	3.94	**2862.80**	

Home Delivered Meals Total:						**63916.93**
Home Delivered Meals	Meal	67	205.60	4.64	**63916.93**	
Specialized Medical Equipment and Supplies Total:						**34577.63**
Specialized Medical Equipment and Supplies	Item	67	8.70	59.32	**34577.63**	
Community Transition Services Total:						**8878.48**
Community Transition Services	Each	13	1.00	682.96	**8878.48**	
In Home Nurse Delegation Total:						**8490.00**
In Home Nurse Delegation	Each	20	50.00	8.49	**8490.00**	

GRAND TOTAL:	**2042648.71**
Total Estimated Unduplicated Participants:	**200**
Factor D (Divide total by number of participants):	**10213.24**
Average Length of Stay on the Waiver:	271

Appendix J: Cost Neutrality Demonstration

J-2: Derivation of Estimates (6 of 9)

d. Estimate of Factor D.

i. Non-Concurrent Waiver. Complete the following table for each waiver year. Enter data into the Unit, # Users, Avg. Units Per User, and Avg. Cost/Unit fields for all the Waiver Service/Component items. Select Save and Calculate to automatically calculate and populate the Component Costs and Total Costs fields. All fields in this table must be completed in order to populate the Factor D fields in the J-1 Composite Overview table.

Waiver Year: Year 2

Waiver Service/ Component	Unit	# Users	Avg. Units Per User	Avg. Cost/ Unit	Component Cost	Total Cost
Personal Care Total:						**1659062.00**
Personal Care	Day	200	271.00	30.61	**1659062.00**	
Personal Emergency Response Total:						**31085.60**
Personal Emergency Response	Day	100	254.80	1.22	**31085.60**	
Environmental Accessibility Adaptations Total:						**73752.80**
Environmental Accessibility Adaptations	Job	67	2.60	423.38	**73752.80**	
Skilled Nursing Total:						**52853.13**
Skilled Nursing	Visit	33	135.50	11.82	**52853.13**	
Transportation Total:						**2034.52**
Transportation	Trip	7	216.90	1.34	**2034.52**	

Home Health Aide Total:						**149148.19**
Home Health Aide	Visit	33	183.80	24.59	**149148.19**	
Adult Day Care Total:						**13743.68**
Adult Day Care	Day	7	192.30	10.21	**13743.68**	
Caregiver/Recipient Training Services Total:						**2950.00**
Caregiver/Recipient Training Services	Hour	7	103.80	4.06	**2950.00**	
Home Delivered Meals Total:						**65845.46**
Home Delivered Meals	Meal	67	205.60	4.78	**65845.46**	
Specialized Medical Equipment and Supplies Total:						**35615.19**
Specialized Medical Equipment and Supplies	Item	67	8.70	61.10	**35615.19**	
Community Transition Services Total:						**9144.85**
Community Transition Services	Each	13	1.00	703.45	**9144.85**	
In Home Nurse Delegation Total:						**8740.00**
In Home Nurse Delegation	Each	20	50.00	8.74	**8740.00**	

GRAND TOTAL:	**2103975.41**
Total Estimated Unduplicated Participants:	**200**
Factor D (Divide total by number of participants):	**10519.88**
Average Length of Stay on the Waiver:	271

Appendix J: Cost Neutrality Demonstration

J-2: Derivation of Estimates (7 of 9)

d. Estimate of Factor D.

i. Non-Concurrent Waiver. Complete the following table for each waiver year. Enter data into the Unit, # Users, Avg. Units Per User, and Avg. Cost/Unit fields for all the Waiver Service/Component items. Select Save and Calculate to automatically calculate and populate the Component Costs and Total Costs fields. All fields in this table must be completed in order to populate the Factor D fields in the J-1 Composite Overview table.

Waiver Year: Year 3

Waiver Service/ Component	Unit	# Users	Avg. Units Per User	Avg. Cost/ Unit	Component Cost	Total Cost
Personal Care Total:						**1708926.00**
Personal Care	Day	200	271.00	31.53	**1708926.00**	
Personal Emergency Response Total:						**32104.80**
Personal Emergency Response	Day	100	254.80	1.26	**32104.80**	

Environmental Accessibility Adaptations Total:						**75965.14**
Environmental Accessibility Adaptations	Job	67	2.60	436.08	**75965.14**	
Skilled Nursing Total:						**54418.16**
Skilled Nursing	Visit	33	135.50	12.17	**54418.16**	
Transportation Total:						**2095.25**
Transportation	Trip	7	216.90	1.38	**2095.25**	
Home Health Aide Total:						**153636.58**
Home Health Aide	Visit	33	183.80	25.33	**153636.58**	
Adult Day Care Total:						**14160.97**
Adult Day Care	Day	7	192.30	10.52	**14160.97**	
Caregiver/Recipient Training Services Total:						**3037.19**
Caregiver/Recipient Training Services	Hour	7	103.80	4.18	**3037.19**	
Home Delivered Meals Total:						**67773.98**
Home Delivered Meals	Meal	67	205.60	4.92	**67773.98**	
Specialized Medical Equipment and Supplies Total:						**36681.90**
Specialized Medical Equipment and Supplies	Item	67	8.70	62.93	**36681.90**	
Community Transition Services Total:						**9419.15**
Community Transition Services	Each	13	1.00	724.55	**9419.15**	
In Home Nurse Delegation Total:						**9000.00**
In Home Nurse Delegation	Each	20	50.00	9.00	**9000.00**	

GRAND TOTAL:	**2167219.12**
Total Estimated Unduplicated Participants:	**200**
Factor D (Divide total by number of participants):	**10836.10**
Average Length of Stay on the Waiver:	271

Appendix J: Cost Neutrality Demonstration

J-2: Derivation of Estimates (8 of 9)

d. Estimate of Factor D.

i. Non-Concurrent Waiver. Complete the following table for each waiver year. Enter data into the Unit, # Users, Avg. Units Per User, and Avg. Cost/Unit fields for all the Waiver Service/Component items. Select Save and Calculate to automatically calculate and populate the Component Costs and Total Costs fields. All fields in this table must be completed in order to populate the Factor D fields in the J-1 Composite Overview table.

Waiver Year: Year 4 *(renewal only)*

Waiver Service/ Component	Unit	# Users	Avg. Units Per User	Avg. Cost/ Unit	Component Cost	Total Cost
Personal Care Total:						**1760416.00**
Personal Care	Day	200	271.00	32.48	**1760416.00**	
Personal Emergency Response Total:						**33124.00**
Personal Emergency Response	Day	100	254.80	1.30	**33124.00**	
Environmental Accessibility Adaptations Total:						**78243.67**
Environmental Accessibility Adaptations	Job	67	2.60	449.16	**78243.67**	
Skilled Nursing Total:						**56072.61**
Skilled Nursing	Visit	33	135.50	12.54	**56072.61**	
Transportation Total:						**2155.99**
Transportation	Trip	7	216.90	1.42	**2155.99**	
Home Health Aide Total:						**158246.29**
Home Health Aide	Visit	33	183.80	26.09	**158246.29**	
Adult Day Care Total:						**14591.72**
Adult Day Care	Day	7	192.30	10.84	**14591.72**	
Caregiver/Recipient Training Services Total:						**3131.65**
Caregiver/Recipient Training Services	Hour	7	103.80	4.31	**3131.65**	
Home Delivered Meals Total:						**69840.26**
Home Delivered Meals	Meal	67	205.60	5.07	**69840.26**	
Specialized Medical Equipment and Supplies Total:						**37783.58**
Specialized Medical Equipment and Supplies	Item	67	8.70	64.82	**37783.58**	
Community Transition Services Total:						**9701.77**
Community Transition Services	Each	13	1.00	746.29	**9701.77**	
In Home Nurse Delegation Total:						**9270.00**
In Home Nurse Delegation	Each	20	50.00	9.27	**9270.00**	

GRAND TOTAL:	**2232577.54**
Total Estimated Unduplicated Participants:	**200**
Factor D (Divide total by number of participants):	**11162.89**
Average Length of Stay on the Waiver:	271

Appendix J: Cost Neutrality Demonstration

J-2: Derivation of Estimates (9 of 9)

d. Estimate of Factor D.

i. Non-Concurrent Waiver. Complete the following table for each waiver year. Enter data into the Unit, # Users, Avg. Units Per User, and Avg. Cost/Unit fields for all the Waiver Service/Component items. Select Save and Calculate to automatically calculate and populate the Component Costs and Total Costs fields. All fields in this table must be completed in order to populate the Factor D fields in the J-1 Composite Overview table.

Waiver Year: Year 5 *(renewal only)*

Waiver Service/ Component	Unit	# Users	Avg. Units Per User	Avg. Cost/ Unit	Component Cost	Total Cost
Personal Care Total:						**1812990.00**
Personal Care	Day	200	271.00	33.45	**1812990.00**	
Personal Emergency Response Total:						**34143.20**
Personal Emergency Response	Day	100	254.80	1.34	**34143.20**	
Environmental Accessibility Adaptations Total:						**80590.15**
Environmental Accessibility Adaptations	Job	67	2.60	462.63	**80590.15**	
Skilled Nursing Total:						**57771.78**
Skilled Nursing	Visit	33	135.50	12.92	**57771.78**	
Transportation Total:						**2216.72**
Transportation	Trip	7	216.90	1.46	**2216.72**	
Home Health Aide Total:						**162977.30**
Home Health Aide	Visit	33	183.80	26.87	**162977.30**	
Adult Day Care Total:						**15035.94**
Adult Day Care	Day	7	192.30	11.17	**15035.94**	
Caregiver/Recipient Training Services Total:						**3226.10**
Caregiver/Recipient Training Services	Hour	7	103.80	4.44	**3226.10**	
Home Delivered Meals Total:						**71906.54**
Home Delivered Meals	Meal	67	205.60	5.22	**71906.54**	
Specialized Medical Equipment and Supplies Total:						**38914.40**
Specialized Medical Equipment and Supplies	Item	67	8.70	66.76	**38914.40**	
Community Transition Services Total:						**9992.84**
Community Transition Services	Each	13	1.00	768.68	**9992.84**	
In Home Nurse Delegation						

Total:						**9550.00**
In Home Nurse Delegation	Each	20	50.00	9.55	**9550.00**	

GRAND TOTAL:	**2299314.97**
Total Estimated Unduplicated Participants:	**200**
Factor D (Divide total by number of participants):	**11496.57**
Average Length of Stay on the Waiver:	271